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Attorneys for Defendant  
ROBERT T. BROCKMAN

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA,  
  
Plaintiff,  
  
v.  
  
ROBERT T. BROCKMAN,  
  
Defendant.

Case No. 3:20-cr-00371-WHA

DECLARATION OF KATHRYN  
KENEALLY IN SUPPORT OF  
DEFENDANT ROBERT T.  
BROCKMAN'S MOTION FOR A  
HEARING TO DETERMINE  
WHETHER MR. BROCKMAN IS  
COMPETENT TO ASSIST IN HIS  
DEFENSE

**DECLARATION OF KATHRYN KENEALLY**

I, Kathryn Keneally, declare as follows:

1. I am a member of the bar of the State of New York, the United States Supreme Court, and various other federal courts. I am a partner of the law firm Jones Day, counsel for the defendant Robert T. Brockman. I make this Declaration in support of Defendant Robert T. Brockman's Motion For a Hearing to Determine Whether Mr. Brockman is Competent to Assist in His Defense.

GOVERNMENT  
EXHIBIT

4:21-CR-009-GCH  
No. 78

- 1 -

Decl. of Kathryn Keneally in Support of Mot. For Hearing to Determine Whether Mr. Brockman is Competent to Assist in His Defense 3:20-cr-00371-WHA

1           2.       Upon graduation from law school in 1982, I served as a law clerk to the Honorable  
2 Edward R. Neaher, for the U.S. District Court for the Eastern District of New York. From April  
3 2012 to June 2014, I served as the Assistant Attorney General for the Department of Justice Tax  
4 Division. At all other times, I have been in private practice, focused primarily on tax controversy  
5 and criminal tax defense. I am a fellow of the American College of Tax Counsel.

6           3.       I do not, and do not intend, to waive Mr. Brockman's attorney-client privilege or  
7 work product protection by this declaration or otherwise. I am not disclosing any  
8 communications with Mr. Brockman in which he sought or we provided legal advice. I disclose  
9 below only discussions between Mr. Brockman and me concerning his medical condition, and my  
10 observations concerning his health and ability to assist in his defense.

11          4.       Based on my professional experience, I know that it is vital to have the assistance  
12 of a client in understanding the complex and far-reaching allegations at issue in this case. It is my  
13 firm belief that Mr. Brockman cannot provide this assistance.

14          5.       I first learned from Mr. Brockman that he had been diagnosed with Parkinson's  
15 disease and dementia on July 18, 2019. Mr. Brockman was meeting with Peter J. Romatowski of  
16 my firm. I participated in that meeting by conference call. I recall that Mr. Brockman said that  
17 he was surprised by these diagnoses. He said that this may explain why he had some difficulties  
18 in our discussions with him. He asked that we address issues with him more slowly, and said that  
19 he may have some difficulty remembering and that he may need to review things several times to  
20 understand what he needed to know. He did not ask whether this would have any impact on the  
21 investigation.

22          6.       Unlike Mr. Brockman, I was not surprised by the diagnoses that he described  
23 during the July 18, 2019 conference. By that time, I had observed that Mr. Brockman had been  
24 unable to provide us with information as to past events at issue in the then on-going investigation.  
25 He would forget discussions that we would have, or relate back to us information that we had  
26 provided to him as if he had remembered it rather than having heard it from us. For me, his  
27 discussion of his medical diagnoses made immediate sense of these experiences.

1           7.     During a telephone call with Mr. Brockman within a few days of the July 18, 2019  
2 discussion, I asked him to send us copies of the medical reports. He did so several weeks later, in  
3 late September 2019, following multiple requests from me.

4           8.     Attached hereto as Exhibit A is a copy of an email exchange between  
5 Mr. Brockman and Dr. Stuart Yudofsky dated May 3-4, 2017.

6           9.     Attached hereto as Exhibit B is a copy of the biography for Seth Lerner, M.D.

7           10.    Attached hereto as Exhibit C is a copy of the biography for James Pool, M.D.

8           11.    Attached hereto as Exhibit D is a copy of the biography for Joseph Jankovic, M.D.

9           12.    Attached hereto as Exhibit E is a copy of the biography for Melissa Yu, M.D.

10          13.    Attached hereto as Exhibit F is a copy of the biography for Michele York, Ph.D.

11          14.    Dr. Pool previously provided a Declaration dated November 25, 2020, in support  
12 of Mr. Brockman's Motion to Transfer Proceedings to the United States District Court for the  
13 Southern District of Texas. ECF No. 49-2. For the Court's convenience, another copy of  
14 Dr. Pool's Declaration is attached hereto as Exhibit G.

15          15.    Attached hereto as Exhibit H is a copy of the medical report for the examination of  
16 Mr. Brockman conducted by Dr. Jankovic on January 30, 2019.

17          16.    Attached hereto as Exhibit I is a copy of the neuropsychological evaluation  
18 Mr. Brockman conducted by Dr. York on March 1, 2019.

19          17.    Attached hereto as Exhibit J is a copy of the medical report for the examination of  
20 Mr. Brockman conducted by Dr. Yu on March 20, 2019.

21          18.    Shortly after sending us his medical reports, Mr. Brockman also sent me  
22 Dr. Pool's report from his annual physical, conducted on October 1, 2019, a copy of which is  
23 attached hereto as Exhibit K.

24          19.    After reviewing the medical reports, I spoke with each of Dr. Pool, Dr. Jankovic,  
25 Dr. Yu, and Dr. York. I learned from Dr. Pool, Dr. Yu, and Dr. York that they thought that the  
26 more likely diagnosis should be Lewy body dementia. I also learned that the precise diagnosis  
27 cannot be confirmed ante-mortem.  
28



1           20. I explained to each of the doctors that my firm represented Mr. Brockman in a  
2 criminal investigation by the U.S. Department of Justice. I asked questions to help me better  
3 understand their medical reports and information generally about each of their diagnoses. The  
4 information that I learned in my discussions with these doctors resonated fully with my  
5 experience in working with Mr. Brockman.

6           21. I asked each of the doctors for his or her opinion as to whether Mr. Brockman's  
7 dementia would prevent him from assisting with his defense. Dr. Pool, Dr. Jankovic, and Dr. Yu,  
8 who are all medical doctors, each responded in words to the effect that Mr. Brockman could not  
9 access his memories reliably to be able to assist in his defense.

10          22. I asked Dr. Pool, Dr. Jankovic, and Dr. Yu to provide me with letters that  
11 summarized our discussions, and explained to each of them that I planned to provide these letters  
12 to the Department of Justice.

13          23. Attached hereto as Exhibit L is a copy of Dr. Pool's letter to me dated January 14,  
14 2020.

15          24. Attached hereto as Exhibit M is a copy of Dr. Jankovic's letter to me dated  
16 January 14, 2020.

17          25. Attached hereto as Exhibit N is a copy of Dr. Yu's letter to me dated January 21,  
18 2020.

19          26. When I spoke with Dr. York, she said that as a neuropsychologist she should  
20 perform a different battery of tests, that she referred to as forensic tests, which she said she  
21 administered when asked to provide an opinion in a legal proceeding. She agreed to perform this  
22 additional battery of tests to evaluate Mr. Brockman. Attached hereto as Exhibit O is a copy of  
23 her neuropsychological report in connection with this evaluation, which was done on December  
24 3, 2019.

25          27. Attached hereto as Exhibit P is a copy of the diagnostic report and images of a  
26 DaTscan performed on Mr. Brockman on February 14, 2019.

27          28. I provided copies of the doctors' medical reports and letters, Dr. York's two  
28 neuropsychological reports, and the DaTscan to the government as part of a letter submission

1 dated April 9, 2020. In a telephone conference on April 23, 2020, we urged the prosecutors to  
2 consider Mr. Brockman's inability to assist in his defense, and to investigate this issue before  
3 reaching any decision whether to seek an indictment. We offered to make Mr. Brockman  
4 available to be examined by a doctor of the government's choosing. We asked that the  
5 government interview Mr. Brockman's doctors. I volunteered that we would not prepare these  
6 witnesses for any interviews, nor would we require that defense counsel be present. Following  
7 the call, I obtained waivers pursuant to the Health Insurance Portability and Accountability Act  
8 ("HIPAA waivers") from Mr. Brockman, which I forwarded to the government to facilitate any  
9 interviews.

10 29. In September 2020, I learned from Mr. Brockman that he had scheduled his annual  
11 examination with Dr. Pool. By this time, based on my experience in speaking with  
12 Mr. Brockman, it was my perception that his ability to understand the information that I provided  
13 or to respond to my inquiries had diminished noticeably. I concluded that we should take the  
14 opportunity of Mr. Brockman's scheduled examination to get updated evaluations of his cognitive  
15 abilities.

16 30. I spoke with the lead prosecutors on September 30, 2020. I let them know that  
17 Mr. Brockman would again be examined by Dr. Pool, and that I planned to ask Dr. Pool to refer  
18 him to Dr. York for an updated evaluation, and to follow up with both doctors. I explained that,  
19 in light of my commitment not to interfere with any interviews that the government may want to  
20 conduct of the doctors, I wanted them to know that I would be speaking again with Dr. Pool and  
21 Dr. York. The prosecutors next contacted me by email on Friday, October 9, to arrange a call for  
22 Saturday, October 10, 2020. During that call, they disclosed that there was a sealed Indictment,  
23 which I later learned is dated October 1, 2020, and they asked for assurance that Mr. Brockman  
24 would attend an arraignment to be scheduled on the following Thursday, October 15, 2020.

25 31. Following Mr. Brockman's arraignment, I spoke again with each of the four  
26 doctors. None of them had been contacted by the government prior to the Indictment. On  
27 October 21, 2020, I informed the prosecutors by email that Mr. Brockman had revoked the  
28 HIPAA waivers.

1           32. In advance of Mr. Brockman's annual examination, I asked Dr. Pool to provide me  
2 with updated findings concerning Mr. Brockman's dementia. Attached hereto as Exhibit Q is a  
3 copy of Dr. Pool's report of that examination, which was performed on October 5, 2020.

4           33. On my request, Dr. Pool referred Mr. Brockman to Dr. York for an updated  
5 evaluation. I asked Dr. York to repeat the battery of tests that she had previously performed on  
6 December 3, 2019. Attached hereto as Exhibit R is a copy of her neuropsychological report in  
7 connection with this evaluation, which was done on October 7, 2020.

8           34. I asked Dr. York to prepare a composite of one aspect of all three of her  
9 examinations of Mr. Brockman, in which she asked him to draw a clock. Attached hereto as  
10 Exhibit S is a copy of that composite.

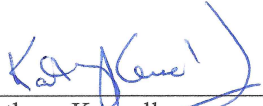
11           35. The defense has identified other witnesses, including Mr. Brockman's wife, and  
12 others who know him on a day-to-day basis, who will provide first-hand experience of his  
13 cognitive limitations at a hearing in this matter.

14           36. Mr. Brockman fully retired on November 6, 2020.

15           37. The government has estimated that it will produce 1.1 terabytes (the equivalent of  
16 22 million pages) of discovery.

17 I declare under penalty of perjury that the foregoing is true and correct.

18 Executed in New York, New York on December 8, 2020.

19  
20  
21   
22 Kathryn Keneally  
23  
24  
25  
26  
27  
28

# **EXHIBIT A**

**To:** Bob Brockman[bob\_brockman@reyrey.com]  
**From:** Stuart Yudofsky[stuart.yudofsky@gmail.com]  
**Sent:** Thur 5/4/2017 12:27:18 AM (UTC)  
**Subject:** Anosmia

Good evening, Bob:

There are dozens of potential causes of anosmia--as there are for memory loss.

If you are comfortable doing so, I suggest that you begin by meeting with me. That will help me assess the severity and significance of your memory symptoms, as well as utilize this information to direct you to the best professional-- discipline, person, and/or system--for assessment and, as required, care.

As you know, Bob, I am a neuropsychiatrist and have extensive hands-on experience with memory and cognitive changes.

I am available in the mornings from 9 AM until noon over the next several days, and can be available at any time over the weekend.

Please let me know how you would like to proceed.

Warmest regards,

Stuart

On May 3, 2017, at 4:27 PM, Bob Brockman <[bob\\_brockman@reyrey.com](mailto:bob_brockman@reyrey.com)> wrote:

Stuart,

Robert and Dorothy are after me to consult with the right doctor regarding my loss of my sense of smell.

They are afraid that it is an early sign of alzheimer's or dementia.

I am feeling good but am having increasing memory problems.

Is there a doctor that you can recommend?

Bob



# **EXHIBIT B**



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Seth Paul Lerner, M.D.,  
FACS

Professor  
713-798-  
4001

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## Email

[slerner@bcm.edu](mailto:slerner@bcm.edu)

## Positions

## **Professor**

Urology

Baylor College of Medicine

Houston, TX US

Beth and Dave Swalm Chair in Urologic Oncology Director of Urologic Oncology Director of the Multidisciplinary Bladder Cancer Program

---

# Addresses

## **Baylor College of Medicine Medical Center (Clinic)**

7200 Cambridge, Suite 10B

Houston, TX 77030

United States

(713) 798-4001

---

# Education

## **B.A. from University Of Texas At Austin**

01/1979 - Austin, TX United States

## **M.D. from Baylor College Of Medicine**

01/1984 - Houston, TX United States

## **Internship at Virginia Mason Hospital**

01/1985 - Seattle, Washington United States

## **Residency at Virginia Mason Hospital**

06/1986 - Seattle, Washington United States

General Surgery

## **Residency at Baylor College of Medicine**

06/1990 - Houston, Texas United States

Urology

## **Fellowship at University Of Southern California**

06/1992 - Los Angeles, California United States

Urologic Oncology

---

## Certifications

American Board of Urology

---

## Professional Interests

- Urologic Oncology and Reconstructive Surgery with Interest in Minimally Invasive Surgery
- 

## Professional Statement

Seth P. Lerner, MD, is Professor of Urology and holds the Beth and Dave Swalm Chair in Urologic Oncology, in the Scott Department of Urology, Baylor College of Medicine. He is Director of Urologic Oncology and the Multidisciplinary Bladder Cancer Program and Faculty Group Practice Medical Director for the Urology Clinic.

He earned his medical degree from Baylor College of Medicine, completed a surgical internship at Virginia Mason Hospital in Seattle, and returned to Baylor for his residency training. He completed a two-year fellowship at the University of Southern California in urologic oncology and reconstructive surgery under Peter Jones and Don Skinner before returning to join the full-time Baylor faculty in 1992. His clinical practice, education, and research activities are devoted to urologic oncology and particularly lower and upper tract urothelial cancer.

Dr. Lerner is author of over 190 peer-reviewed articles, and co-editor of a comprehensive Textbook of Bladder Cancer. He is the founding co-editor-in-chief of the Bladder Cancer journal. He established and directs the multi-disciplinary Bladder Cancer Research Program at Baylor and his research interests include use of selective estrogen receptor modulators for treatment of bladder cancer, gene therapy, integrated genomic analysis of bladder and upper urinary tract cancers, and outcomes of radical cystectomy and pelvic lymphadenectomy. He has 26 years experience as a clinical investigator for both NCI and industry funded clinical trials. He is the PI of the ongoing SWOG NCI Phase III trial comparing extended vs. standard pelvic lymphadenectomy at time of radical cystectomy. He is active in the leadership of several national bladder cancer research enterprises including chair of the Local Bladder Cancer committee of SWOG, founding and former co-chair of the NCI Bladder Cancer Task Force and current co-chair of the NCI CTEP Genitourinary Steering Committee, and he has co-chaired the Analysis Working Group of The Cancer Genome Atlas Project

for muscle invasive bladder cancer for the past 7 years. He is very active in the Bladder Cancer Advocacy Network (BCAN) as a member of the Board of Directors, past chair of the Bladder Cancer Think Tank and co-chair of the management committee of the Bladder Cancer Research Network. Dr. Lerner is an active member of the prestigious American Association of Genitourinary Surgeons and is listed routinely among "America's Top Doctors" and "Best Doctors in America."

---

## Websites

[Scott Department of Urology](#)

[Dr. Lerner's Research](#)

[VIICTR Research Database](#)

[BCM MyChart](#)

---

## Selected Publications

- Levitt JM, Jian W, Lerner SP, Sonpavde G "A conventional preclinical schedule of cisplatin is more effective than a metronomic frequent bolus schedule for urothelial carcinoma.." *Urol. Oncol.* 2013 February ; 31 (2): 234-40. Pubmed PMID: [21723160](#)
- Burke JM, Lamm DL, Meng MV, Nemunaitis JJ, Stephenson JJ, Arseneau JC, Aimi J, Lerner S, Yeung AW, Kazarian T, Maslyar DJ, McKiernan JM "A First in Human Phase 1 Study of CG0070, a GM-CSF Expressing Oncolytic Adenovirus, for the Treatment of Nonmuscle Invasive Bladder Cancer.." *J. Urol.* 2012 December ; 188 (6): 2391-7. Pubmed PMID: [23088985](#)
- Meeks JJ, Bellmunt J, Bochner BH, Clarke NW, Daneshmand S, Galsky MD, Hahn NM, Lerner SP, Mason M, Powles T, Sternberg CN, Sonpavde G "A Systematic Review of Neoadjuvant and Adjuvant Chemotherapy for Muscle-invasive Bladder Cancer.." *Eur. Urol.* 2012 September ; 62 (3): 523-33. Pubmed PMID: [22677572](#)
- Jian PY, Godoy G, Coburn M, Lynch G, Ro JY, Zhai QJ, Nishino M, Lerner SP "Adenocarcinoma following urinary diversion.." *Can Urol Assoc J.* 2012 April ; 6 (2): E77-80. Pubmed PMID: [22511440](#)

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---

## Memberships



**American Association of Genitourinary Surgeons**

Member

**American Urological Association**

Member

**American Association for Cancer Research**

Member

**American Association for the Advancement of Science**

Member

**American College of Surgeons**

Fellow

**American Medical Association**

Member

**American Society of Clinical Oncology**

Member

**American Society of Gene Therapy**

Member

**American Association of Clinical Urologists**

Member

**Harris County Medical Society**

Member

**International Bladder Cancer Network**

Member

**Society of Basic Urologic Research**

Member

**Société Internationale D'Urologie**

Member

**Society of Laparoendoscopic Surgeons**

Member

## **South Central Section of the American Urological Association**

Member

## **Society of University Urologists**

Member

## **Southwest Oncology Group**

Member

## **Texas Urological Society**

Member

## **Texas Medical Association**

Member

---

# Skills

### **Research Interests**

Bladder Cancer Collaborative Research Program: Role of estrogen receptors and the use of selective estrogen receptor modulators (e.g., tamoxifen) for treatment of bladder cancer; novel targeted therapeutics and gene therapy for treatment of non-muscle-invasive and invasive disease; outcome of treatments for non-muscle-invasive bladder cancer and radical cystectomy and development of predictive models; genomic characterization and integrated analysis of bladder and upper tract cancers

### **Clinical Interests**

Urologic oncology and urinary tract reconstruction; management of patients with bladder, prostate, testis and kidney cancer; Director, Bladder Cancer Multidisciplinary Clinical Program

### **Clinical Trials**

Bladder cancer; prostate cancer; kidney cancer

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James L Pool, M.D.

Professor  
713-798-  
5800

## Email

[jpool@bcm.edu](mailto:jpool@bcm.edu)

## Positions

## **Professor**

Medicine-Hypertension  
Baylor College of Medicine  
Houston, TX US

## **James L. Pool Presidential Endowed Chair in Clinical Pharmacology**

Baylor College of Medicine  
Houston, Texas United States

---

# Addresses

## **Baylor Comprehensive Healthcare Clinic (Clinic)**

1977 Butler Blvd. E6.150  
Houston, TX 77030  
United States  
(713) 798-0180

---

# Education

## **MD from University Of Oklahoma School of Medicine**

06/1972 - Oklahoma City, Oklahoma United States

## **Internship at Duke University Medical Center**

01/1973 - Durham, North Carolina United States  
Internal Medicine

## **Residency at Duke University Medical Center**

01/1975 - Durham, North Carolina United States  
Internal Medicine

## **Fellowship at Duke University Medical Center**

01/1976 - Durham, North Carolina United States  
Endocrinology

---

# Certifications

## Internal Medicine

American Board of Internal Medicine

## Diplomate

American Board of Endocrinology and Metabolism

## Diplomate

American Board of Clinical Pharmacology

---

# Professional Interests

- Cardiovascular Pharmacology
  - Alteration of Lipid Metabolism by Antihypertensive Drugs
  - Autonomic Nervous System Dysfunction
- 

# Websites

[VIICTR Publications List](#)

[Cardiovascular Disease Prevention Care Center](#)

---

# Selected Publications

- Taylor AA, Pool JL "[Clinical role of direct Renin inhibition in hypertension..](#)" *Am J Ther.* 2012 May ; 19 (3): 204-10. Pubmed PMID: [21317620](#)
- Perlstein TS, Henry RR, Mather KJ, Rickels MR, Abate NI, Grundy SM, Mai Y, Albu JB, Marks JB, Pool JL, Creager MA "[Effect of angiotensin receptor blockade on insulin sensitivity and endothelial function in abdominally obese hypertensive patients with impaired fasting glucose..](#)" *Clin. Sci.* 2012 February 1; 122 (4): 193-202. Pubmed PMID: [21861845](#)
- Hyman DJ, Pavlik VN, Greisinger AJ, Chan W, Bayona J, Mansyur C, Simms V, Pool J "[Effect of a physician uncertainty reduction intervention on blood pressure in uncontrolled hypertensives-a cluster randomized trial..](#)" *J Gen Intern Med.* 2012 April ; 27 (4): 413-9. Pubmed PMID: [22033742](#)
- Clement S, Brohan E, Sayce L, Pool J, Thornicroft G "[Disability hate crime and targeted violence and hostility: A mental health and discrimination perspective..](#)" *J Ment Health.* 2011 June ; 20 (3):

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Joseph Jankovic, M.D.

Professor  
713-798-  
6556

[Request Clinical Appointment](#)

## Email

[pdcmddc@bcm.edu](mailto:pdcmddc@bcm.edu)

## Positions

**Professor**

Neurology  
Baylor College of Medicine

**Distinguished Chair in Movement Disorders**

Baylor College of Medicine

**Director**

Parkinson's Disease Center and Movement Disorders Clinic  
Baylor College of Medicine

**Director, Centers of Excellence**

National Parkinson Foundation

Huntington's Disease Society of America Tourette Syndrome Association

**Program Director**

Movement Disorders Fellowship  
Baylor College of Medicine

---

## Addresses

**Parkinson's Disease Center and Movement Disorders Clinic (Clinic)**

Baylor College of Medicine Medical Center  
7200 Cambridge St., 9th Floor, MS: BCM609  
Houston, TX 77030  
United States  
(713) 798-2273  
[Neurology Site](#)

---

## Education

**MD from University of Arizona College of Medicine**

06/1973 - Tucson, Arizona United States

**Internship at Baylor College of Medicine**

06/1974 - Houston, Texas United States

Internal Medicine

**Residency at The Neurological Institute, Columbia University**

06/1977 - New York, NY United States

Neurology

---

## Certifications

American Board of Psychiatry and Neurology, Neurology

---

## Honors & Awards

**Past President**

International Parkinson and Movement Disorder Society (01/1994 - 01/1996)

**Honorary Member**

American Neurological Association Australian Association of Neurologists European Federation of Neurological Societies French Neurological Society International Parkinson and Movement Disorder Society

**Great Teacher Award**

National Institutes of Health

**Movement Disorders Research Award**

Sponsored by the Parkinson's Disease Foundation

American Academy of Neurology

**Distinguished Service Award**

National Parkinson Foundation

**Guthrie Family Humanitarian Award**

Huntington's Disease Society of America

**Lifetime Achievement Award**

Tourette Syndrome Association

**Distinguished Service Award**

Dystonia Medical Research Foundation

### **Distinguished Faculty Award**

Baylor College of Medicine Alumni Association

### **Fulbright and Jaworski Faculty Excellence Award**

Baylor College of Medicine

### **Master Clinician Lifetime Award**

Baylor College of Medicine

### **Past President**

International Neurotoxin Association (01/2015 - 12/2017)

---

## Professional Interests

- Neurology
  - Movement Disorders
  - Parkinson's Disease and related neurodegenerative disorders
  - Tremors
  - Dystonia
  - Tics
  - Tourette's syndrome
  - Chorea
  - Huntington's disease
  - Restless leg syndrome
  - Tardive dyskinesias
  - Paroxysmal dyskinesias
  - Ataxia
- 

## Professional Statement

Joseph Jankovic, M.D. is Professor of Neurology, Distinguished Chair in Movement Disorders, and Founder and Director of the Parkinson's Disease Center and Movement Disorders Clinic (PDCMDC), Department of Neurology, Baylor College of Medicine, Houston, Texas. After completing his Neurology training at Columbia University, New York City, he joined the faculty of Baylor College of

Medicine in 1977. Since that time he has led clinical and research team that focuses on etiology, pathophysiology, and experimental therapeutics of Parkinson's disease and related neurodegenerative and movement disorders such as tremors, dystonia, Tourette syndrome, Huntington disease, restless legs syndrome, tardive dyskinesia, and paroxysmal dyskinesias. Under the direction of Dr. Jankovic the PDCMDC has been recognized as "Center of Excellence" by the Parkinson's Foundation, the Huntington Disease Society of America, the Tourette Association of America, and the Wilson Disease Association.

Past president of the International Parkinson and Movement Disorder Society and of the International Neurotoxin Association, Dr. Jankovic is the recipient of many awards including the American Academy of Neurology Movement Disorders Research Award, First National Parkinson Foundation Distinguished Service Award, Huntington's Disease Society of America Guthrie Family Humanitarian Award, Tourette Syndrome Association Lifetime Achievement Award, Dystonia Medical Research Foundation Distinguished Service Award, Benign Essential Blepharospasm Research Foundation Award, and Lifetime Achievement Award from the International Neurotoxin Association, Dr. Jankovic has published over 1,200 original articles and over 55 books, is included among "Highly Cited Researchers", and has been ranked #1 expert in the world in movement disorders and in botulinum toxins (<http://expertscape.com/>).

He has served as the principal investigator in hundreds of clinical trials and his pioneering research on drugs for parkinsonian disorders and hyperkinetic movement disorders has led to their approval by the Food and Drug Administration. Dr. Jankovic is current or past member of many scientific and medical advisory boards and has served on the executive scientific advisory boards of the Michael J. Fox Foundation for Parkinson's Research and the National Parkinson Foundation. Dr. Jankovic has mentored numerous fellows and other trainees many of whom have become leaders in the field of neurology and movement disorders. For further information visit [www.jankovic.org](http://www.jankovic.org).

---

## Websites

[Parkinson's Disease Center and Movement Disorders Clinic](#)

[In the News](#)

[Dr. Jankovic's Bibliography](#)

Comprehensive list of publications and presentations

[Dr. Jankovic's Research](#)

VIICTR Research Database

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---

# Videos

[Joseph Jankovic, M.D. - Giving Life to Possible](#)

Joseph Jankovic, M.D. is board certified in psychiatry and neurology specializing in movement disorders and Parkinson's disease. His clinical interests include: movement disorders, Parkinson's disease and related neurodegenerative disorders.

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# **EXHIBIT E**



## COVID-19 Response



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Melissa Michelle Yu, M.D.,  
FAAN

Associate  
Professor  
713-798-  
2273

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## Positions

**Associate Professor**

Neurology

Baylor College of Medicine

**Associate Medical Director**

Baylor Clinic  
Neurology  
Baylor College of Medicine

**Associate Director, Clinical Operations**

Alzheimer's Disease and Memory Disorders Center  
Baylor College of Medicine  
Houston, Texas

**Faculty Senator**

Baylor College of Medicine  
Houston, Texas United States

**Physician Informaticist**

Baylor College of Medicine

---

## Addresses

**Baylor Neurology - Alzheimer's Disease and Memory Disorders Center (Clinic)**

7200 Cambridge St., 9th Floor  
McNair Campus  
Houston, TX 77030  
United States  
(713) 798-4734  
<https://www.bcm.edu/healthcare/care-centers/neurology>

---

## Education

**MD from Mt. Sinai School of Medicine**

05/2000 - New York City, New York United States

**Internship at St. Luke's-Roosevelt Hospital Center**

06/2001 - New York City, New York United States  
Internal Medicine

**Residency at Baylor College of Medicine**

06/2004 - Houston, Texas United States

Neurology

**Graduate Certificate at Jesse H. Jones Graduate School of Management of Rice University**

03/2014 - Houston, Texas United States

Healthcare Management

**Graduate Certificate at University of Texas, School of Biomedical Informatics**

12/2016 - Houston, Texas United States

Healthcare Informatics

---

## Certifications

**Neurology**

American Board of Psychiatry and Neurology

**Clinical Informatics**

American Board of Preventive Medicine

---

## Professional Interests

- Memory disorders
  - Healthcare Management
  - Electronic Medical Records
  - Process Improvement
  - Quality Improvement
  - Healthcare Informatics
- 

## Memberships

**American Academy of Neurology**

---

## Languages

Spanish

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# **EXHIBIT F**



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Michele K York, Ph.D.,  
ABPP-CN

Professor  
713-798-  
8673

[Request Clinical Appointment](#)

## Email

[myork@bcm.edu](mailto:myork@bcm.edu)

## Positions



### **Professor**

Neurology and Psychiatry and Behavioral Sciences  
Baylor College of Medicine

### **Head**

Section of Neuropsychology  
Baylor College of Medicine

---

## Addresses

### **Baylor College of Medicine Medical Center (Clinic)**

7200 Cambridge St., 9th Floor  
Houston, TX 77030  
United States  
(713) 798-8673

---

## Education

### **Internship at Baylor College Of Medicine**

01/2000 - Houston, Texas United States  
Clinical Psychology

### **PhD from Vanderbilt University**

01/1998 - Nashville, Tennessee United States

### **MA from Vanderbilt University**

01/1996 - Nashville, Tennessee United States

### **BA from Vanderbilt University**

01/1993 - Nashville, Tennessee United States

---

## Certifications

### **Clinical Neuropsychology**

American Board of Professional Psychology

---

## Honors & Awards

### **Fulbright and Jaworski LLP Faculty Excellence Award for Teaching and Evaluation**

Baylor College of Medicine (01/2012)

### **Fulbright and Jaworski LLP Faculty Excellence Award for Enduring Materials**

Baylor College of Medicine (09/2012)

### **Norton Rose Fulbright LLP Faculty Education Award for Teaching and Evaluation**

Baylor College of Medicine (09/2018)

### **Norton Rose Fulbright LLP Faculty Education Award for Enduring Materials**

Baylor College of Medicine (01/2019)

### **Star Award for Clinical Excellence**

Baylor College of Medicine (01/2019)

---

## Websites

[VIICTR Publications List](#)

[Neuropsychology](#)

[In the News](#)

[Dr. York's Bibliography](#)

Comprehensive list of publications and presentations

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---

## Selected Publications

- Hack N, Akbar U, Thompson-Avila A, Fayad SM, Hastings EM, Moro E, et al "[Impulsive and Compulsive Behaviors in Parkinson Study Group \(PSG\) Centers Performing Deep Brain Stimulation Surgery.](#)" *J Parkinsons Dis.* 2014 January 1; 4 (4): 591-8. Pubmed PMID: 25035311
- Rothlind JC, York MK, Carlson K, Luo P, Marks WJ, Jr, et al "[Neuropsychological changes following deep brain stimulation surgery for Parkinson's disease: comparisons of treatment at](#)

pallidal and subthalamic targets versus best medical therapy." *J Neurol Neurosurg Psychiatry*. 2014 September 2; : Pubmed PMID: 25185211

- Fridley J, Adams G, Sun P, York M, Atassi F, Lai E, et al "Effect of subthalamic nucleus or globus pallidus interna stimulation on oculomotor function in patients with Parkinson's disease." *Stereotact Funct Neurosurg*. 2013 91 (2): 113-21. Pubmed PMID: 23343617
- Calleo J, Burrows C, Levin H, Marsh L, Lai E, York MK "Cognitive rehabilitation for executive dysfunction in Parkinson's disease: application and current directions.." *Parkinsons Dis*. 2012 2012 : 512892. Pubmed PMID: 22135762

[Show 34 more selected publications](#)

## Memberships

### Academy of Distinguished Educators

Member (01/2012)

### American Academy of Neurology

### Movement Disorders Society

### International Neuropsychological Society

### Parkinson Study Group

### American Congress of Rehabilitation Medicine

Co-Chair Elect (09/2018)

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# EXHIBIT G

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Attorneys for Defendant  
ROBERT T. BROCKMAN

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA,  
  
Plaintiff,  
  
v.  
  
ROBERT T. BROCKMAN,  
  
Defendant.

Case No. 3:20-cr-00371-WHA

DECLARATION OF JAMES L. POOL,  
M.D., IN SUPPORT OF ROBERT T.  
BROCKMAN'S MOTION TO  
TRANSFER PROCEEDINGS

**DECLARATION OF JAMES L. POOL, M.D.**

I, James L. Pool, M.D., declare as follows:

1. I am a Professor in the Departments of Medicine and Pharmacology and a treating internal medicine physician at the Baylor College of Medicine, in Houston, Texas, where I hold the James L. Pool Presidential Endowed Chair in Clinical Pharmacology.

2. I make this Declaration at the request of his counsel in support of Mr. Brockman's Motion to Transfer Proceedings to the United States District Court for the Southern District of Texas.

1           3.       Mr. Brockman was referred to me by Dr. Seth P. Lerner (Baylor College of  
2       Medicine, Department of Urology), who had previously treated Mr. Brockman for bladder cancer.  
3       I conducted a complete physical examination of Mr. Brockman on December 11, 2018. It  
4       became evident from my examination that Mr. Brockman was experiencing movement disorders  
5       and cognitive problems that are consistent with Parkinson's disease or parkinsonism.

6           4.       I referred Mr. Brockman to three other medical professionals: Joseph Jankovic,  
7       M.D., a neurologist and specialist in Parkinson's disease and other movement disorders; Melissa  
8       Yu, M.D., a neurologist and specialist in Alzheimer's Disease and other memory disorders; and  
9       Michele K. York, Ph.D., a neuropsychologist, all with Baylor College of Medicine.

10          5.       Each of these doctors provided me with reports following their examinations.  
11       Their conclusions support that Mr. Brockman presented symptoms that are consistent with  
12       Parkinson's Disease, parkinsonism, Lewy body dementia, or some combination. These diagnoses  
13       cannot be totally confirmed except at autopsy. None of these conditions are curable, and each  
14       may result in rigid muscles, slow movements, and tremors. All are characterized by progressive  
15       dementia, and in Mr. Brockman's case, the medical reports confirm cognitive impairment, which  
16       includes, but is not limited to, both short and long term memory loss.

17          6.       I examined Mr. Brockman again on October 6, 2020. At that time, I conducted  
18       cognitive tests, and again referred Mr. Brockman to Dr. York for a further battery of tests. The  
19       results of these examinations confirm that Mr. Brockman's impairment is progressive.

20          7.       At this stage, Mr. Brockman may be oriented in time and place, aware of persons  
21       in his company, able to engage in social conversation, and capable of functioning in familiar  
22       tasks. However, Mr. Brockman's progressive dementia impairs his cognitive ability in several  
23       respects. These include short term memory limitations. In addition, his condition renders long-  
24       term memory inaccessible and defective. For these reasons, I concur with the medical position  
25       that Mr. Brockman cannot assist his attorneys in his defense.

26          8.       I understand that Mr. Brockman's counsel will make a motion for a hearing to  
27       determine that Mr. Brockman cannot assist in his defense, and that this motion will be supported  
28       by the medical reports and letters previously provided to them by me, Dr. Jankovic, Dr. Yu, and



1 Dr. York. I also understand that counsel will want to present testimony from each of us to  
2 explain how we reached our conclusions. We are all based in Houston. Under ordinary  
3 circumstances, it would be difficult for us to be present for a hearing in San Francisco, where this  
4 court is located. Under the current circumstances of the COVID-19 pandemic, we would be  
5 confronted with the increased risk of exposure at a time when the Centers for Disease Control and  
6 Prevention and other medical advisors are counseling against travel, the potential need to  
7 quarantine before and after travel, and the detrimental impact any absence or illness may have on  
8 our other patients.

9 9. It is also not medically advisable for Mr. Brockman to travel to San Francisco for a  
10 hearing or for trial. Mr. Brockman is 79 years old and suffers from underlying medical  
11 conditions that put him at increased risk for severe illness if he were to contract COVID-19.

12 10. Additionally, requiring Mr. Brockman to face legal proceedings in a location  
13 distant from his home will be disorienting in a manner that could accelerate the deterioration of  
14 his mental condition. Unfamiliar environments, stimulating surroundings, and changes in routine  
15 would be especially stressful for a person with Mr. Brockman's diminished capacity, creating a  
16 risk to his existing cardiac condition, and could exacerbate the overall progression of his  
17 symptoms.

18 11. Based on the foregoing, I respectfully submit this Declaration in support of Mr.  
19 Brockman's Motion to Transfer Proceedings to the United States District Court for the Southern  
20 District of Texas.

21 12. I declare under penalty of perjury that the foregoing is true and correct.

22  
23 Executed in Houston, Texas on November 25, 2020.

24  
25  
26   
James L. Pool, M.D.

# EXHIBIT H

## **Brockman, Robert Theron**

MRN: 0300937767

**Office Visit** 1/30/2019      Provider: Jankovic, Joseph, MD (Neurology)  
Baylor College of Medicine -      Primary diagnosis: PD (Parkinson's disease)  
Neurology Associates      Reason for Visit: Movement Disorder; Referred by Pool, James L, MD

### **Additional Documentation**

Vitals:      BP 136/79 (BP Location: left arm, Patient Position: Sitting, Cuff Size: regular) Pulse 53  
Ht 6' 1" (1.854 m) BMI 25.07 kg/m<sup>2</sup> BSA 2.11 m<sup>2</sup>      [More Vitals](#)  
Flowsheets:      MDS UPDRS  
Encounter Info:      [Billing Info](#), [History](#), [Allergies](#), [Detailed Report](#)

### **Media**

[Scan on 1/31/2019 9:44 AM by Garcia, Karen, CMA: Montreal Cognitive Assessment \( MOCA \)](#)

### **Progress notes**

**Savitt, Daniel, DO at 2/8/2019 1:50 PM**

Author Type: Fellow      Status: Addendum  
Editor: Savitt, Daniel, DO (Fellow)

**PT NAME:** Robert Theron Brockman  
**MRN:** 0300937767  
**DOB:** [REDACTED]

**INITIAL NEUROLOGICAL EVALUATION:** 1/30/2019

**REFERRING PHYSICIAN:** Pool, James L, MD and Stuart Yudofsky, MD

#### **REASON FOR EVALUATION:**

We had the pleasure of evaluating Mr. Brockman at the Parkinson's Disease Center and Movement Disorders Clinic at Baylor College of Medicine on 1/30/2019. He presents for evaluation and treatment of Parkinson's disease.

#### **HISTORY OF PRESENT ILLNESS:**

Mr. Brockman is a 77 year old ambidextrous man, the CEO of a computer software company, who presents for evaluation of possible Parkinson's disease.

The onset of symptoms began 1.5 years ago with concentration and memory difficulty. He developed depressive symptoms about 6 months ago for which bupropion was started 2 months ago. Since that time, he has noticed an improvement in his thinking and memory. He also noticed difficulty with his balance about 1.5 years ago. For example, he enjoys fly-fishing as a hobby and has more difficulty standing even in calm waters. He takes shorter steps and has a stooped posture with walking. There is no freezing and no change in his arm swing.

He has stiffness when he does not exercise. He is moving more slowly in general as well. His handwriting is messier and smaller and for this reason, he has stopped signing employee certificates. He has not noticed a significant tremor. He has some difficulty with

tasks requiring fine motor movements such as buttoning certain buttons and starting the line for his fly-fishing.

He has developed near absence of sense of smell about 10 years ago. He also began acting out his dreams at nighttime 2-3 years ago, kicking and punching in his sleep. He generally sleeps well, although recent work stress has disrupted his sleep and he now takes melatonin. He has increased urinary frequency (he goes hourly) and urgency but without incontinence or retention. He had constipation when he started Cardizem 2.5 years ago, that resolved with stool softeners. He does not have hypophonia but his wife notices slower speech. He has excessive salivation. For the past 6-8 months, he has had difficulty swallowing food and medications, coughs with swallowing. He has reduction in his hearing but does not want to wear hearing aids.

He has never been prescribed antiemetics or antipsychotics and has never been treated for these symptoms.

**DIAGNOSTIC TESTS:**

MRI brain (11/2/19): Unremarkable

**RESPONSE TO TREATMENT:**

None

**ALLERGY:** No Known Allergies

**Current Outpatient Medications**

Medication	Sig	Dispense	Refill
• buPROPion (WELLBUTRIN SR) 100 MG SR tablet	Take 100 mg by mouth two times daily. 200mg each morning and 100mg each evening		
• diltiazem (DILTIAZEM CD) 120 MG ER capsule	Take 120 mg by mouth daily.		
• ELIQUIS 2.5 MG TABS	TAKE 1 TABLET TWICE DAILY		2
• ezetimibe-simvastatin (VYTORIN) 10-40 MG per tablet	Take 1 Tab by mouth every evening.		
• levothyroxine (SYNTHROID) 75 MCG tablet	Take 75 mcg by mouth daily.		
• Multiple Vitamins-Minerals (MULTIVITAMIN ADULT OR)	Take by mouth.		
• Testosterone (ANDROGEL) 50 MG/5GM GEL	Place onto the skin.		

No current facility-administered medications for this visit.

**PAST MEDICAL HISTORY:**

**Past Medical History:**

Diagnosis

Date

- Atrial fibrillation

- Basal cell carcinoma
- Bladder cancer
- Depression
- Hypercholesteremia
- Melanoma
- Ocular migraine 1/2012  
*lasted ~30 minutes*
- Prostatitis 1980
- Prostatitis
- Pseudoexfoliation glaucoma(365.52)
- Thyroid disease
- UTI (lower urinary tract infection)

**PAST SURGICAL HISTORY:**

**Past Surgical History:**

Procedure	Laterality	Date
• HX BLADDER TUMOR EXCISION		2006
• HX DENTAL SURGERY <i>infected tooth</i>		
• HX TONSILLECTOMY		1945

**FAMILY HISTORY:**

Heritage: Caucasian

Mother: Diabetes. She had a mediastinal mass that was inoperable (possibly lymphoma) but deferred treatment.

Father: COPD

There is no family history of Parkinson's disease or tremor.

**SOCIAL HISTORY:**

Marital Status: Married

Education: 1 year of graduate school

Occupation: CEO/founder of a computer software company

Lives with his wife.

**Social History**

**Tobacco Use**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

**Substance Use Topics**

- Alcohol use: Yes

**REVIEW OF SYSTEMS:**

**GENERAL:** The patient denies fevers, chills, weight loss, or weight gain.

**EYES:** The patient denies dry eyes, blurry vision, double vision, or vision loss.

**EARS/NOSE/THROAT:** The patient denies hearing loss, voice changes, rhinorrhea, dry mouth, or sore throat.

**CARDIOVASCULAR:** The patient denies chest pain, palpitations, irregular heartbeat, or lightheadedness.

**RESPIRATORY:** The patient denies cough, shortness of breath, or asthma.

**GI:** The patient denies nausea, vomiting, diarrhea, constipation, bowel incontinence, ulcers, or reflux.

**GU:** The patient denies bladder incontinence, dysuria, urinary urgency, or frequency.  
**HEME:** The patient denies anemia, easy bruising, easy bleeding, or a clotting disorder.  
**DERMATOLOGIC:** The patient denies rash, suspicious lesions, or change in skin color.  
**ENDOCRINE:** Patient denies heat or cold intolerance, hair loss, diabetes, or thyroid problems.  
**MUSCULOSKELETAL:** The patient denies joint or back pain, joint swelling, arthritis, ankle swelling, or muscle aches.  
**PSYCHIATRIC:** The patient denies hallucinations, delusions, insomnia, or a history of bipolar disorder, OCD, ADD, ADHD. The patient has depression, anxiety, and memory loss.  
**NEUROLOGIC:** The patient denies tremor, headaches, seizures, strokes, paresthesias, weakness, or sexual dysfunction. The patient has stiffness, gait imbalance, and hearing abnormalities.

**PHYSICAL EXAMINATION:**

**Sitting**

**Vitals:**

01/30/19 0911  
BP: 136/79  
BP Location: left arm  
Patient: Sitting  
Position:  
Cuff Size: regular  
Pulse: 53  
Height: 6' 1" (1.854 m)

**General:** The patient is well appearing and in no distress.  
**Skin:** No rashes.  
**HEENT:** Normocephalic and atraumatic.  
**Neck:** Supple to palpation.  
**Cardiovascular:** Regular rate and rhythm.  
**Lungs:** Clear to auscultation bilaterally.  
**Peripheral Vascular System:** No edema and normal distal pulses.  
**Abdomen:** Nontender, soft.  
**Extremities:** No cyanosis or edema.  
**Visual:** No visual field abnormalities.  
**Psychiatric:** There is appropriate mood and affect.  
**Musculoskeletal:** No arthritic signs.

**NEUROLOGICAL EXAMINATION:**

**Mental Status:** The patient is alert and oriented to person, time, and place. Speech is fluent with good comprehension. There are no abnormal perceptions, hallucinations, delusions, or illusions. The patient is able to follow three-step commands. There is no right/left disorientation, ideomotor or constructional apraxia, or evidence of ADHD or OCD. A MoCA examination was administered and the patient received a score of 19/30.  
**Cranial Nerve Examination:** Pupils are equal, round, and reactive to light. Visual fields are full. Non-dilated funduscopic examination revealed normal retinal and vascular anatomy. No evidence of Kayser-Fleischer rings. Ocular movements are full with no evidence of nystagmus or abnormal saccades. There are no square-wave jerks. Normal light touch within the distribution of the fifth cranial nerve. No facial asymmetry or dysarthria. Hearing is normal to finger rub bilaterally. Tongue and palate are in the midline. 5/5 trapezius strength.

**Motor Examination:** The patient has normal bulk, and 5/5 strength in the upper and lower extremities.

**Rigidity:** 2+ in each leg.

**Bradykinesia:** Mild bradykinesia worse on the right.

**Involuntary Movements:** There is no evidence of myoclonus, tics, chorea, or dystonic postures.

**Tremor:** 2+ kinetic tremor and 1+ postural tremor in each arm.

**Reflexes:** 2/4 and symmetric in the biceps, triceps, brachioradialis, quadriceps, and ankle jerks. Plantar response is flexor.

**Sensation:** Normal to joint position, temperature, light touch, and vibration in all the extremities.

**Coordination:** The patient has normal finger-nose-finger and heel-to-shin. There is no evidence of dysdiadochokinesis with rapid alternating movements.

**Gait, Balance and Posture:** The patient is able to arise from a chair without hesitation. There is reduced stride length, stooped posture, absent arm swing and en bloc turning. Romberg is normal. There is 1+ postural instability.

**Rating Scales:** MDS- UPDRS was completed in the electronic chart.

**IMPRESSION:** Mr. Brockman is a 77 year old ambidextrous man, the CEO of a computer software company, who presents for evaluation of Parkinson's disease. The onset of symptoms began 1.5 years ago with walking and balance difficulty. He developed shorter steps, stooped posture, and more difficulty maintaining balance, especially when standing in water while fishing. He has also noticed slowness of movement, difficulty with dexterity, micrographia, anosmia, and dream-acting behavior (REM-Behavioral Disorder). He had an MRI brain in 11/2018 that was unremarkable. His examination is significant for a MoCA of 19/30, 2+ leg rigidity, mild bradykinesia, and a parkinsonian gait. His history and examination are consistent with the diagnosis of postural instability gait difficulty (PIGD) type Parkinson's disease. Vascular parkinsonism is also a possible consideration given his lower body predominant symptoms and presence of vascular risk factors that include atrial fibrillation hypertension, and hyperlipidemia.

#### **RECOMMENDATIONS:**

1. The diagnosis of Parkinson's disease or possible vascular parkinsonism was discussed with the patient and his wife.
2. An information packet was provided about Parkinson's disease.
3. The following tests were requested:
  - DaTscan to evaluate for dopaminergic deficiency and differentiate between vascular parkinsonism and idiopathic Parkinson's disease.
  - Has appointment scheduled for neuropsychiatric testing.
  - Will place referral to Stromatt driving evaluation due to concerns for safety with driving.
4. We prescribed the following medications and treatments:
  - Start carbidopa/levodopa 25/100 and titrate to 2 tablets three times daily. Written titration instructions were provided.
5. We would like to see the patient for follow-up in 4 months.

We discussed with the patient the indications and potential side effects of the prescribed treatment.

I personally interviewed and examined the patient, and agree with the above report. It has been our privilege to evaluate this patient.

This report was electronically signed by:  
Joseph Jankovic, M.D./ Daniel Savitt, D.O.  
Professor of Neurology/ Movement Disorders Fellow

**Joseph Jankovic, MD**  
Professor of Neurology  
Distinguished Chair in Movement Disorders  
Director, Parkinson's Disease Center  
and Movement Disorders Clinic  
Baylor College of Medicine  
Department of Neurology  
Baylor St. Luke's Medical Center at the McNair Campus  
7200 Cambridge, 9th Floor, Suite 9A  
Houston, TX 77030-4202  
Tel: 713-798-2273  
[www.jankovic.org](http://www.jankovic.org)

cc:  
Dr. James Poole  
6620 Main St.  
Houston, TX 77030  
713-798-0180

Dr. Stuart Yudofsky  
1 Baylor Plz #115D  
Houston, TX 77030  
713-798-4945

**Revision History** ✓

**Jankovic, Joseph, MD at 1/30/2019 11:16 AM**

Author Type: Physician Status: Signed  
Editor: Jankovic, Joseph, MD (Physician)

I personally saw and evaluated the patient, and reviewed the Vitals, History, Allergies and Medications sections of the electronic medical record. I agree with the findings as written by the fellow, resident, nurse practitioner.

**JOSEPH JANKOVIC, M.D.**  
Professor of Neurology  
Distinguished Chair in Movement Disorders  
Director, Parkinson's Disease Center  
and Movement Disorders Clinic  
Baylor College of Medicine  
Department of Neurology  
7200 Cambridge, Suite 9A, MS: BCM 609  
Houston, TX 77030-4202  
Tel: 713-798-2273 or -6556

Fax: 713-798-6808

Web: [www.jankovic.org](http://www.jankovic.org)



No questionnaires available.

### Patient Instructions

1. We discussed the diagnosis of Parkinson's disease.
2. We ordered a DaTscan to evaluate for dopamine deficiency related to Parkinson's disease.
3. You have been prescribed Sinemet 25/100mg tablets.
  - Please take this medication with food unless otherwise instructed.
  - Common potential side effects may include nausea, sleepiness, dizziness, or hallucinations.
 Please call 713-798-7438 if you experience these or other side effects.

	<u>BRKFST</u>	<u>LUNCH</u>	<u>DINNER</u>
WEEK 1	1		1
WEEK 2	1	1	1
WEEK 3	2	2	2

4. We will also send a referral for an independent driving evaluation.

### AVS Reports

Date/Time	Report	Action	User
1/30/2019 11:27 AM	After Visit Summary	Printed	Savitt, Daniel, DO
1/30/2019 11:16 AM	After Visit Summary	Automatically Generated	Jankovic, Joseph, MD

### Follow-up and Disposition

Return in about 3 months (around 4/30/2019).

### Orders Placed

NM DATSCAN BRAIN SPECT (Resulted 2/14/2019)

### Medication Changes

As of 1/30/2019 11:27 AM

	Refills	Start Date	End Date
Added: carbidopa-levodopa (SINEMET) 25-100 MG per tablet Take 2 Tabs by mouth 3 times daily. - ORAL	1	1/30/2019	
Apixaban Discontinued or Completed: Apixaban (ELIQUIS OR)			

	Refills	Start Date	End Date
Unchanged: ELIQUIS 2.5 MG TABS TAKE 1 TABLET TWICE DAILY	2	8/4/2018	
Discontinued or Completed: diltiazem (CARDIZEM SR) 60 MG SR capsule			
Discontinued or Completed: doxycycline (VIBRAMYCIN) 100 MG capsule			
Discontinued or Completed: levofloxacin (LEVAQUIN) 750 MG tablet			
Discontinued or Completed: Metoprolol Succinate (TOPROL XL OR)			
Discontinued or Completed: nitrofurantoin (MACRODANTIN) 100 MG capsule			

### Visit Diagnoses

PD (Parkinson's disease) G20  
Cognitive decline R41.89  
RBD (REM behavioral disorder) G47.52

# EXHIBIT I



**Michele K. York, PhD, ABPP-CN**  
Board Certified Clinical Neuropsychologist  
Associate Professor  
Department of Neurology

## CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Robert Brockman  
Date of Birth (Age): [REDACTED] 77 yr.)  
Date(s) of Evaluation: 03/01/2019  
Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor  
Referred by: James Pool, MD  
Referral Question: Differential Diagnosis  
CPT Code: 96116 (60 mins) 96121 (120 mins) 96136 (30 mins) 96137 (180 mins) 96132 (60 mins)  
96133 (180 mins)

### BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 77 year-old, right-hand dominant, Caucasian male with a two to three year history of short-term memory loss. He was referred by his physician for neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning with the aim of informing medical differential diagnosis and facilitating clinical decision making. The following information was obtained during a clinical interview with Mr. Brockman and from available medical records.

**Current Concerns and General Condition:** Mr. Brockman and his spouse participated in the clinical interview. He was able to act as a reliable informant. Mr. Brockman reported declines in his short-term memory over the past 2 to 3 years. He reported that he is repeating himself, losing possession, and losing his train of thought and is more tangential. He forgets names of new individual and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and has hit curbs while driving and parking. He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking.

Mr. Brockman reported that he began taking Wellbutrin which has improved his mood. He noted that "It is clear that he is working too much." He denied anhedonia, depressed mood, heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he is a night owl and dozes off during the day. His wife reported that he began to act out his dreams a couple of years ago. He has decreased appetite and has lost weight. His wife noted that he does not speak as much. He reported that he has floaters in his visual fields. He denied visual hallucinations, but it is noted that later he pointed out a bug on the testing room floor that was not present to either the examiner or his wife.

**Medical History:** Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, tremor, micrographia, and back problems. He currently has plantar fasciitis, so he is not walking for exercise. He reported that he was hospitalized for a prostate infection four years ago and pericarditis. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa one month ago. His wife noted an improvement when he first started on the medication, but since the medication was increased, she reported that he has increasing clumsiness. He is scheduled to be evaluated by Dr. Jankovic for his movement disorder. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical

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history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. He has been taking bupropion for two months, which has reportedly improved his mood significantly. He is taking trazodone to aid his sleep and reducing his REM Behavior Disorder. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines. Please refer to his chart for a listing of his current medications. He is on a large regimen of supplements and vitamins.

**Social History:** Mr. Brockman has been married for 50 years and they have one son. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

**Behavioral Observations:** Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his spouse who participated in the clinical interview. General appearance was neat and clean. He exhibited shuffling and slow gait, slowed motor behavior, and a right hand tremor. His mood was neutral, and he had a flat affect. He had a masked face. Eye movements were normal. Vision (with corrective lenses) and hearing were adequate for the testing session. Conversational speech was coherent and goal-directed, but it was sparse with short phrases. There was no evidence of paraphasias. He evidenced a slight stutter at times. He showed moderately decreased ability to follow directions, and he frequently needed repetition of directions and to be reoriented to task. He perseverated to previous tasks. The examiner needed to be concrete for him to understand the task instructions. His processing speed was extremely slow. He was cooperative but evidenced surrendering test-taking behavior. His attitude towards the examiner was appropriate and friendly. He lacked insight into his cognitive problems. During testing, the patient said he was not doing well, but he appeared very surprised. His handwriting was micrographic. He saw a bug on the floor of the testing room that was not present. The following results are thought to be an accurate estimation of his current cognitive abilities.

#### MEASURES ADMINISTERED

Montréal Cognitive Assessment (MoCA); Caregiver Neuropsychiatric Inventory (NPI-Q); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVLT-R); Neuropsychological Assessment Battery (NAB subtest: Naming); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Fluency Test; Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Test of Premorbid Functioning (TOPF); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition); Instrumental Activities of Daily Living Scale (IADLS); Lawton and Brody Physical Self-Maintenance Scale (PSMS). Clinical Interview with patient and his spouse.

Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) and Wisconsin Card Sorting Test (WCST) measures due to cognitive/behavioral problems.

Informant questionnaires were sent home and completed by the patient's spouse. They were not returned by the time of the evaluation.

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**Michele K. York, PhD, ABPP-CN**  
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Associate Professor  
Department of Neurology

### NEUROPSYCHOLOGICAL FINDINGS

*The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).*

**Mental Status:** Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is below expectation. He was oriented (6/6) and short-term recall was 2/5. He was aided by category cueing for one word. He demonstrated difficulties with set shifting, drawing a cube, drawing a clock face with numbers and hands placed accurately, repeating one sentence, and with serial 7's and verbal fluency.

**Intellectual:** Premorbid level of intellectual functioning was estimated to be in the high average range (TOPF SS=114), based on single, atypical word reading skills. Mr. Brockman noted that the first word presented for him to read aloud was not a word ("two"). He was able to state the letters, but noted that he did not think that was a word and then stated he guessed it was two. Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from borderline to high average yielding a pro-rated Full Scale IQ estimate of 87, which is in the low average range.

**Attention/Concentration:** Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was low average with 7 digits forward, 3 digits backward, and 2 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was borderline impaired. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was borderline impaired with 0 errors.

**Executive:** Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was deficient. His abstract verbal reasoning was high average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued.

**Memory:** Recall of culturally-based general knowledge was average. Immediate recall of verbally presented contextual material was deficient (SS=3). Delayed recall of the stories was deficient (SS=3). Retention of initially learned material was 11.1%. Recognition memory was average (16/23). Mr. Brockman began describing the WMS VR figures during LM immediate recall. Incremental learning for a semantically-categorized word list across 3 trials was borderline impaired (2, 5, and 6 words per trial), and delayed recall was in the deficient range with 0.0% retention which falls within the deficient range. On recognition memory assessment, 9/12 target words were correctly identified, 5 false positive errors were committed, with discrimination accuracy in the deficient range.

Immediate recall of basic geometric figures was deficient (SS=1). Delayed recall of the designs was deficient (SS=2). Retention of the initially learned material was 0.0%. Recognition memory was borderline impaired (1/7).

**Language:** Lexical fluency was low average with between 9 and 13 words per trial. Semantic fluency was deficient with 8 exemplars generated. Confrontation naming of pictured objects was average (29/31).

**Visual-Perceptual:** His drawing of a complex geometric design scored in the deficient range. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was impaired



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to command (CDT=3/10). He drew a micrographic clock face. The examiner produced a clock face for him, but he was unable to place the numbers accurately and drew a hand to the 10 and the 6 for 10 after 11. His copy of a clock was also impaired (CDT=6/10). He drew the clock face but the numbers were drawn in only the right side of the face and the hand size differentiation was not maintained.

**Mood / Personality:** On a self-report measure of anxiety, his responses fell in the mild range (GAD-7=7/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of within normal limits (GDS=8): boredom, feeling as though something negative is going to occur, preferring to stay home, worry about the future, declines in memory, poor energy, difficulties with concentration, and preferring to avoid social gatherings.

**Activities of Daily Living:** His spouse served as the informant completing a questionnaire regarding the patient's ability to complete basic and instrumental activities of daily living. Mr. Brockman reportedly has difficulties with self-care ADLs (PSMS=7/30) including ambulation. He requires mild assistance with instrumental activities of daily living (IADLs=9/31), most notably housekeeping. Although his wife did not report many functional declines, Mr. Brockman requires mild aid with his more complex ADLs.

**Neurobehavioral:** The patient's spouse completed an inventory assessing for the presence of neurobehavioral symptoms commonly associated with dementia, reportedly observing mild problems with agitation, anxiety, apathy, irritability, nighttime behaviors, and changes in appetite with moderate depression (NPI-Q severity=8; distress=11) which produce an overall minimal level of familial distress, with the exception of his depression and agitation which produces moderate distress.

### SUMMARY AND IMPRESSION

Mr. Brockman is a 77 year-old, right-hand dominant, Caucasian male who was referred by his physician for evaluation of his current neuropsychological, behavioral, and emotional status. He currently operates in the low average range of general intellectual functioning (WAIS-IV FSIQ=87), which is a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, and changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produces moderate distress.

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuoconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming.

This pattern of neuropsychological performance indicates a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. To my knowledge, Mr. Brockman has not been diagnosed with a movement disorder. However, he demonstrates movements that may be consistent with a Parkinsonism. These

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abnormal movements taken together with his current diagnosis of dementia, new onset visual hallucinations and potential visual illusions, and REM Behavior Disorder, his pattern of cognitive impairments is consistent with Dementia with Lewy Bodies.

**RECOMMENDATIONS**

**General:**

- Mr. Brockman and his family should receive feedback regarding his current level of cognitive functioning.
- Continued pharmacologic treatment of his depression appears warranted.
- Mr. Brockman should be monitored for episodes of visual hallucinations. Although he did not report hallucinations on interview, he saw a bug on the floor in the testing room which was not present.
- You may wish to consider referring the patient and his family to psychoeducational counseling with the goal of developing appropriate coping strategies, maximization of current strengths to mitigate identified weaknesses, and assist in future life planning.
- Mr. Brockman does not pose a significant safety risk and as such, he should receive occasional supervision for self-care ADLs for safety and to monitor for future changes in his ability status. He should also receive occasional review of instrumental activities of daily living to monitor for future changes in his ability status, particularly for medication and personal financial management.

**Memory Compensatory Strategies:**

- Mr. Brockman should exercise caution when operating potentially dangerous household appliances (e.g., stove/range, irons, food processors, etc.). Using models with automatic shut-off features would be ideal.
- Mr. Brockman should refrain from cooking activities involving potentially dangerous appliances (e.g., stove, food processor, etc.).
- The use of a smartphone is recommended for recording important information, setting reminders, and is maintaining and organized schedule. Applications such as Google calendar, Remember the Milk, and the Reminders application for the iPhone or similar techniques may be helpful.
- It may be helpful to have a mobile phone or smartphone with him to allow easy access to telephone number he could contact in an emergency or when he cannot recall this information.
- Placing a large-type calendar or clock that includes the date in a highly visible location may assist him in maintaining better temporal orientation.
- The patient may benefit from the placement of a large dry-erase board in a prominent spot in the home where important information can be posted such as the date, the day's or week's schedule, the whereabouts of his spouse/family members, their time to return, or important telephone numbers.
- The patient's family may wish to consider presenting important information that Mr. Brockman needs to recall in a written format when possible to allow him to refer to and review the information as necessary.
- Mr. Brockman and his family should consider establishing a 'memory station' where he would consistently place personal items such as his keys, checkbook/wallet, glasses, etc. to help prevent future memory failures regarding lost objects and to reduce anxiety and misattributions regarding the occurrence of these events. He is also encouraged to use external memory aids such as shopping lists, calendars, timers, a pill minder, and "to do" lists whenever possible to mitigate common, everyday memory failures.
- To the extent possible, he should try to avoid distracting environments when performing detailed tasks such as financial management. Breaking tasks down into more manageable units to prevent overtaxing attentional resources is another possibility. In this way, a large task can be achieved a little at a time over a week instead of an overwhelming task all in one evening, for instance.



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**Social Activities and Other Intellectual Stimulation:**

- The patient is encouraged to maintain or increase (to the extent safely possible) his current level of intellectual and physical stimulation to help improve stamina, buoy his mood, and maintain his current level of quality of life.
- Mr. Brockman may benefit from engaging in intellectual stimulation such as reading, assembling jigsaw puzzles, and other activities such as word search puzzles, crosswords, or Sudoku. Computer-based activities such as [www.Lumosity.com](http://www.Lumosity.com) or [www.happyneuron-corp.com](http://www.happyneuron-corp.com) are options as well. Board games and familiar card or other games (e.g., dominoes, bridge, solitaire, etc.) may also be enjoyable.
- Regular physical exercise is recommended for its beneficial effects on brain health and cognitive maintenance.

**Driving:**

- Neuropsychological tests are an imperfect predictor of real-world driving abilities; however, given his deficits in memory, attention/concentration, executive functions, visuospatial abilities, and his recent diagnosis of DLB, he should be encouraged to discontinue driving given concerns over his safety, that of others on the roadways, and legal liability issues that could arise for the patient should he become involved in a motor vehicle crash.

**Legal:**

- If not already in place, a family member should obtain Durable Power of Attorney for healthcare and financial matters.

**Patient and Caregiver Resources:**

- The Alzheimer's Association ([www.alz.org/texas](http://www.alz.org/texas); 713-314-1314) provides useful information and resources for family members of patients with Alzheimer's and other types of dementia.
- Mr. Brockman and his family may benefit from community resources for seniors in the Houston area at [www.HoustonTx.gov/Health/Aging](http://www.HoustonTx.gov/Health/Aging) and through the Houston Area Parkinson's Society ([hapsonline.org](http://hapsonline.org)).

The current results will be useful as a baseline to which findings from subsequent evaluations may be compared. Neuropsychological re-evaluation is recommended in one year (or sooner if his condition appears to change rapidly or if he and/or his family have additional concerns) to monitor neuropsychological, mood, and personality changes and to update recommendations.

Thank you for allowing me to participate in the care of Mr. Brockman. Please do not hesitate to contact me if you have any further questions.

*Michele K York, PhD*

Michele K. York, PhD, ABPP-CN  
Board Certified Clinical Neuropsychologist

**N.B.** This assessment was conducted as a clinical evaluation and not as a forensic assessment. This fact was verbally confirmed with the patient at the outset of testing.

# **EXHIBIT J**

## Brockman, Robert Theron

MRN: 0300937767


**Office Visit** 3/20/2019  
Baylor College of Medicine  
Neurology

Provider: Yu, Melissa, MD (Neurology)  
Primary diagnosis: Dementia with Parkinsonism  
Reason for Visit: Memory Loss; Referred by Pool, James L, MD

### Additional Documentation

Vitals: BP 135/70 (BP Location: left arm, Patient Position: Standing) Pulse 58  
Ht 5' 11.75" (1.822 m) Wt 189 lb (85.7 kg) BMI 25.81 kg/m<sup>2</sup> BSA 2.08 m<sup>2</sup> More Vitals  
Flowsheets: Mini-Mental State  
Encounter Info: Billing Info, History, Allergies, Detailed Report

### Communications

 Chart Routed to Pool, James L, MD

### Media

Scan on 3/19/2019 9:30 AM by Hudson, Kendra: ADMDC Packet  
Scan on 3/20/2019 2:35 PM by Seedane, Demonica: Clocks

### Progress notes

Yu, Melissa, MD at 3/20/2019 4:58 PM

Author Type: Physician Status: Signed  
Editor: Yu, Melissa, MD (Physician)

**Consult requested by: James L Pool, MD**  
**1977 Butler Blvd**  
**Suite E6.150**  
**Houston, TX 77030**

#### Chief Concern:

#### Chief Complaint

Patient presents with

- Memory Loss

#### HPI:

Robert Theron Brockman is a 77 y.o. male who presents for evaluation of memory loss with his husband and his son.

Memory loss is reported beginning at least back to November 2017 in a Fondren Orthopedics progress note scanned into the chart.

He was recently seen in the PDMDC by Dr. Jankovic at which time he reported a 1.5 year history of cognitive difficulty along with balance difficulty. Anosmia was noted dating back about 10 years, and dream enactment behavior for the past 3 years. Increased tone and tremor was noted as well as reduced arm swing and stride length. Parkinson's disease was

suspected and DATSCAN was performed showing significant loss of dopaminergic signal. He was started on sinemet with motor improvement and started on Exelon patch on 3/13.

He now presents for memory disorders evaluation. He reports always having "superior memory." He reports onset of symptoms about 2 years ago. His wife reports some symptoms about 3 years ago with "slowing down" and then symptoms became much more obvious about 9 months ago associated with a stressful life event. His son notes that he repeats himself at times. He reports mild progression since that time.

He reports always misplacing objects. He reports minimal word finding issues but difficulty with spelling. He reports minimal difficulty with names. He reports some difficulty remembering to take his medications. He has stopped driving at his physician's request. No driving incidents were reported but his wife notes that he drives slower. He reports no trouble managing finances. He never cooks. He notes some difficulty with planning out tasks at work, family notes that he doesn't initiate activity like he used to.

He lost his sense of smell about 10 years ago. He describes his mood as "pretty good" but notes feeling shaken about his neuropsychological test results. His son reports that his ability fluctuates (he's had him draw clocks at various times). He reports episodes of "blankness" associated with less interaction alternating with improved cognition. His son notes significant fluctuations in terms of his decision making abilities, with good days and bad days. His son reports he's not as angry as he used to be.

The patient reports good sleep. At least four episodes of dream enactment behavior is reported and snoring - both have improved with trazodone. He reports awakening feeling refreshed. He does not nap. His family notes he has been more fatigued since being on diltiazem. He sleeps 7-8 hours/night.

He reports one episode of visual disturbance - saw a rainbow/possible visual aura about 8 years ago. No other visual phenomena are reported with the exception of a possible hallucination during neuropsychological testing - wife notes it was a "bad day". No auditory hallucinations are reported.

Motor symptoms began a few years ago with a stooped posture noted by his son. His son also noted increased tone in his back. His gait began to deteriorate in July 2018. He reports no falls. He reports urgency and frequency of urine but no incontinence. He reports some decline in his handwriting and family notes micrographia and decreased facial expression. He reports no sensory changes with the exception of mild tingling in two toes. No visual agnosia is reported.

Gait symptoms improved some with levodopa, particularly on one tab TID. Increase in dose to two tabs TID led to more cognitive decline but family reports he seems to have stabilized in this regard. Cognitively he has improved some with the Exelon patch as well. He reports minimal side effects except feeling spacy at times.

**Past Neurological History:**

**History of Learning Disability:** absent. BS Business. CEO and owner of large automotive dealership software company.

**Previous diagnosis of neurological disease:** None

**Illness which could affect mentation:** None

**History of head injury:** None

**History of visual symptoms:** as above

**History of hearing symptoms:** Decreased Acuity Both. Date of onset: uncertain

**History of abnormal movements:** None

**Previous stroke or TIA: None**  
**Previous seizure: None**

**Past Medical History:**

**Past Medical History:**

Diagnosis	Date
• Atrial fibrillation	2016
• Basal cell carcinoma	
• Bladder cancer	
• Depression	
• Hypercholesteremia	
• Melanoma	
• Ocular migraine	1/2012
lasted ~30 minutes	
• Prostatitis	1980
• Prostatitis	
• Pseudoexfoliation glaucoma(365.52)	
• Thyroid disease	
• UTI (lower urinary tract infection)	

**Past Surgical History:**

**Past Surgical History:**

Procedure	Laterality	Date
• HX BLADDER TUMOR EXCISION		2006
• HX CATARACT REMOVAL		
• HX DENTAL SURGERY		
infected tooth		
• HX TONSILLECTOMY		1945

**Allergies:**

No Known Allergies

**Medications:**

• buPROPion (WELLBUTRIN SR) 100 MG SR tablet	Take 100 mg by mouth two times daily. 200mg each morning and 100mg each evening
• carbidopa-levodopa (SINEMET) 25-100 MG per tablet	Take 2 Tabs by mouth 3 times daily.
• diltiazem (DILTIAZEM CD) 120 MG ER capsule	Take 120 mg by mouth daily.
• ELIQUIS 2.5 MG TABS	TAKE 1 TABLET TWICE DAILY
• ezetimibe-simvastatin (VYTORIN) 10-40 MG per tablet	Take 1 Tab by mouth every evening.
• levothyroxine (SYNTHROID) 75 MCG tablet	Take 75 mcg by mouth daily.
• rivastigmine (EXELON) 4.6 MG/24HR PT24	Apply 1 patch to skin every 24 hrs x 1 month then increase to 2 patches thereafter

- Testosterone (ANDROGEL) 50 MG/5GM Place onto the skin.  
GEL
- trazodone (DESYREL) 50 MG tablet Take 1 Tab by mouth at bedtime.

**Social History:**  
**Social History**

**Tobacco Use**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

**Substance Use Topics**

- Alcohol use: No  
Frequency: Never  
Comment: none for 3 years, previous occasional heavy drinking (not regularly)
- Drug use: No

Occupation: As above

Marital Status: Married, one son who is Neuroscience graduate student

**Family History:**

**Family History**

Problem	Relation	Name	Age of Onset
• Lymphoma	Mother		
• COPD	Father		
• Other (aspergers)	Brother		

Neurological disorders: as above

**Review of Systems:** see health assessment - reviewed with patient

**Constitutional:** No weight change, fever, chills, fatigue

**Eyes:** No diplopia, blurry vision, dry eyes, cataracts, macular degeneration except history of cataract removal

**ENT:** No headache, sinus issues, hearing loss, tinnitus, dry mouth, vertigo except hearing loss reported

**Cardiovascular:** No chest pain, tachycardia, bradycardia. Reports history of angina.

**Respiratory:** No difficulty breathing

**GI:** No abdominal pain, constipation/diarrhea, nausea, incontinence

**GU:** No pain on urination, incontinence, kidney stones. Reports history of bladder cancer, occasional incontinence

**Skin/Teg:** No rash, lacerations, easy bruising. Reports history of basal cell CA and melanoma.

**Musculoskeletal:** No significant neck or back pain, history of arthritis, broken bones except history of osteopenia and arthritis.

**Psychiatric:** No anxiety, reports history of depression

**Endocrine:** No thyroid abnormalities, DM except reports hypothyroidism on synthroid.

**Hematologic:** No anemia, transfusions

**Immunologic:** No recent infections

**Neurologic:** See above

**Vital Signs:**

**Vitals:**

	03/20/19 1304	03/20/19 1307
BP:	140/73	135/70
BP	left arm	left arm
Location:		
Patient	Sitting	Standing
Position:		
Pulse:	53	58
Weight:	189 lb (85.7 kg)	
Height:	5' 11.75" (1.822 m)	

**General Physical Examination:**

Gen: Well developed, well nourished in no apparent distress. Awake and alert.

Neck: supple, full range of motion. No carotid bruits

Cardiac: Rate and rhythm regular without any murmurs and with normal S1 and S2 sounds.

Chest: clear to auscultation, no wheezes, rales or rhonchi, symmetric air entry

Abdomen: soft, nontender, nondistended, no masses or organomegaly

Extremities: no pedal edema

Skin: Intact

**NEUROLOGICAL EXAMINATION:**

**(120 mins post levodopa)**

MMSE 26/30 (7s), 25/30 (spelling) Definite visual issues noted with significant issues noted drawing clock and intersecting pentagons.

Clock drawing 2/4 (circle, numbers, unable to indicate correct time. Numbers on outside of clock)

General behavior: cooperative. Repetitive.

Deficit Anosognosia: Minimizes

Judgement: fair, estimated from: history and observation

Apraxia: absent

**Speech:**

Spontaneous speech: normal

Comprehension: normal

Repetition: normal

Word finding difficulty: present

Dysarthria: absent

**Cranial Nerves**

II: Acuity deferred. VFF. Fundus: No papilledema

III, IV, VI: PERRL, EOMI, no nystagmus

V1-V3: intact to light touch bilaterally

VII: face symmetric

VIII: diminished to finger rub bilaterally

IX, X: palate elevates equally and symmetrically

XI: SCM 5/5

XII: tongue movements symmetric and midline. No fibrillations or atrophy.

#### General Motor Survey

Posture: stooped  
Tone: increased in BUE with distraction  
Atrophy: absent

#### Motor Examination

Power 5/5 throughout.

#### Deep Tendon Reflexes

<u>DTRs</u>	Bic	Tric	BR	Pat	Ankle	Babinski
Right	2+	2+	2+	1+	1+	flexor
Left	2+	2+	2+	1+	1+	flexor

Abnormal reflexes: glabellar and snout and jaw jerk

#### Sensory Examination

Vibration: Normal in both legs except decreased in the toes bilaterally  
Joint Position: Normal in both legs except in the toes bilaterally  
Light Touch: Normal in all 4 extremities  
Pinprick: Normal in all 4 extremities

#### Coordination

Finger to nose: mild action tremor noted bilaterally  
Heel to shin: Normal bilaterally

#### Movement:

Bradykinesia: slow rapid alternating movements noted bilaterally, more pronounced on left. Hypomimia and mild bradyphrenia noted.  
Tremor: no rest tremor noted. Mild postural tremor noted in left more than right hand.  
Other abnormal movements: Single myoclonic jerk (trunk) noted during examination

#### Gait and Station

Gait and posture: stooped posture with minimal arm swing, short steps with en bloc turning noted  
Romberg testing: Normal  
Posture: significant postural instability noted with minimal stimulus  
Able to rise from chair without use of arms

#### Review of Medical Records:

Neuropsychological testing (3/1/19, York):

**IMPRESSION:** Pattern indicates a dementia of mild to moderate severity with deficits in areas of visuospatial functioning, verbal and nonverbal episodic memory and executive functioning, with mild functional declines. Parkinsonism combined with dementia, new onset visual hallucinations, potential visual illusions and REM Behavior disorder are consistent with dementia with Lewy Bodies. Driving cessation recommended.

Prior labs:

Normal: RPR, HIV, homocysteine, CMP, folate, B12, lipid panel, MMA, D, SPEP, A1C, TFTs, CBC, ESR

MRI of the brain 11/2018:



No intracranial abnormalities, particularly no disproportionate lobar atrophy  
Reviewed by me: Mild generalized atrophy, two microhemorrhages in left frontal lobe.

DATSCAN 1/2019:

Severe loss of dopaminergic neuronal function in the bilateral dorsal striata with loss greater on the right compared to the left.

Reviewed by me: Agree

**Physician Estimate of symptom duration (derived using ADMDC methods):**

At least 3 years

**Impression:**

Robert Theron Brockman is a 77 y.o. male with history of atrial fibrillation and bladder cancer who presents for evaluation today with a 3 year history of cognitive dysfunction along with changes in gait, worse over the past 9 months associated with a significant life stressor. Examination is significant for deficits noted on MMSE, visual spatial dysfunction and parkinsonism. Imaging demonstrates loss of dopaminergic function without significant vascular burden. Differential includes Dementia with Lewy Bodies or Parkinson's Disease with dementia. Time course and fluctuations in cognition are more suggestive of DLB.

**Plan:**

I recommended the patient continue the sinemet at the current dose and increase Exelon patch to 9.5mg after one month on the lower dose. I recommended a course of PT for balance and gait. Imaging and laboratory data discussed with patient and family at length. Will get ApoE testing for completeness. Discussed lifestyle changes and maintenance of physical and social activity. Advised patient on diagnosis of a neurodegenerative disorder with cognitive impairment and possible implications on his work and advised he discuss further with his family. Patient and family will return for a counseling session with Dr. Kenan in the future. Patient will return for follow up in 3 months to review effects of Exelon patch.

90 minutes were spent with patient, >50% spent in counseling and coordination of care including education regarding appropriate evaluation and workup for cognitive disorders.

**Thank you for the opportunity to participate in the care of your patient.**

**CC:James L Pool, MD**  
**1977 Butler Blvd**  
**Suite E6.150**  
**Houston, TX 77030**

---

**Melissa Yu, M.D.**  
**Associate Professor**  
**Department of Neurology**  
**Baylor College of Medicine**  
**Houston, TX 77030**

No questionnaires available.

## Patient Instructions

1. After one month, increase the patch to 9.5mg daily (new prescription)
  2. Go to physical therapy
  3. Kendra will call you to set up an appointment with Dr. Kenan
- Follow up with me is recommended in 3 months to see how you're doing.

## AVS Reports

Date/Time	Report	Action	User
3/20/2019 2:33 PM	After Visit Summary	Printed	Yu, Melissa, MD

## Follow-up and Dispositions

- Return in about 3 months (around 6/20/2019).

## Orders Placed

APOLIPOPROTEIN E MUTATION - CARDIAC (Resulted 3/20/2019)  
AMB REF TO PT EXTERNAL Closed

## Medication Changes

As of 3/20/2019 2:24 PM

	Refills	Start Date	End Date
<b>Added: rivastigmine 9.5 MG/24HR PT24</b> Place 9.5 mg onto the skin daily. - Transdermal	5	3/20/2019	
<b>traZODone HCl</b> Discontinued or Completed: TRAZODONE HCL OR			
Unchanged: trazodone (DESYREL) 50 MG tablet	3	3/13/2019	
Take 1 Tab by mouth at bedtime. - ORAL			

## Visit Diagnoses

Dementia with Parkinsonism G31.83, F02.80

# **EXHIBIT K**

BROCKMAN, ROBERT

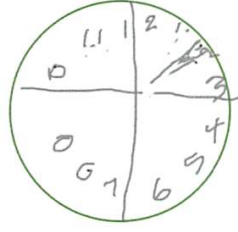
Patient ID: 0300937767

DOB: [REDACTED]

Age: 78

Gender: M

Date: October 01, 2019

SCORE	TODAY	CLOCK DRAWING: TODAY
3-WORD MEMORY	0	
ORIENTATION	6	
SEQUENCE MEMORY	4	
TIME	2	
TOTAL SCORE	12	

### Background

This patient is a 78 year-old man who lives independently in the community. The patient's cognitive functioning is being evaluated due to cognitive complaints by the patient, a family member, or a community observer.

### Test Results

This patient has received a score of 12 of 29 points. This score falls below the cutoff for dementia in patients of this age and educational level and is typically associated with Major Neurocognitive Disorder, moderate (formerly Moderate Dementia). In our research database of 3500 patients, no patients in this score range had normal cognition, 2% had Mild Cognitive Impairment (MCI), and 98% had dementia.

The test administrator agrees with the results of this test.

### Results Over Time




October 2019

### Plan

No plan.

**BROCKMAN, ROBERT**

Patient ID: 0300937767 DOB: [REDACTED] Age: 78 Gender: M



Donna Ansualda

**Disclaimer:** This test has high levels of sensitivity, specificity and reliability, but does not replace comprehensive neuropsychological and medical evaluation. Our recommendations are based on current research and extensive clinical experience with this population. The CogniSense™ tool has been validated in English speaking adults ages 60 to 92 in a community-based primary care setting.

**References:**

Clonsky, M and Clonsky E, "Development and Validation of the Memory Orientation Screening Test," American Journal of Alzheimer's Disease & Other Dementias, 2010, 25 (8), 650-656

Clonsky, M and Clonsky E, "Identifying Cognitive Impairment in the Annual Wellness Visit: Who Can You Trust?," The Journal of Family Practice, 2011, 60: 653-659

Clonsky, M and Clonsky E, "The Memory Orientation Screening Test (MOST®) accurately separates normal from MCI and demented elders in a prevalence-stratified sample," Alzheimer's Disease & Parkinsonism, 2013, 3:1

# **EXHIBIT L**

James L. Pool, M.D.  
Professor, Departments of Medicine and Pharmacology  
Baylor Comprehensive Healthcare Clinic  
Jamail Specialty Care Center  
1977 Butler Blvd - 6<sup>th</sup> Floor, Suite E6.150  
Houston, TX 77030-4101  
Tel 713-798-0180 • Fax 713-798-0174  
E-mail address: jpool@bcm.edu



January 14, 2020

Kathryn Keneally  
Jones Day  
250 Vesey Street  
New York, NY 10281

Re: Robert Theron Brockman



Dear Ms. Keneally:

I have been asked to provide this letter by counsel for Robert T. Brockman. I understand that this letter will be included by counsel as part of a submission to the U.S. Department of Justice on the issue of Mr. Brockman's cognitive impairment.

I am a Professor in the Departments of Medicine and Pharmacology and a treating internal medicine physician at the Baylor College of Medicine (BCM), where I hold the James L. Pool Presidential Endowed Chair in Clinical Pharmacology.

I conducted a complete physical examination of Mr. Brockman on December 11, 2018. Mr. Brockman was referred to me by Dr. Seth P. Lerner (BCM Department of Urology) who has been treating Mr. Brockman in connection with an incidence of urinary bladder cancer several years earlier.

As part of my examination of Mr. Brockman, I also met with his wife, Dorothy Brockman, and their adult son, Robert Brockman. It became evident from my examination and from our discussions that Mr. Brockman has experiencing cognitive problems that have been noticeable for approximately three years. For this reason, Mr. Brockman was referred to Joseph Jankovic, M.D., a BCM neurologist and specialist in Parkinson's Disease and other movement disorders, Melissa Yu, M.D., a BCM neurologist and specialist in Alzheimer's Disease and other memory disorders, and Michele K. York, Ph.D., a BCM neuropsychologist and specialist in memory disorders, all with Baylor Medical College.

Each of these doctors provided me with reports following their examinations. Dr. Jankovic examined Mr. Brockman in January 2019. He conducted a physical examination, and concluded that Mr. Brockman presents symptoms that are consistent with Parkinson's Disease (or Vascular Parkinsonism). Dr. York conducted a neuropsychological evaluation of Mr. Brockman on March 1, 2019, which Dr. Yu relied on during her examination of Mr. Brockman on March 20, 2019, and in her subsequent

Re: Robert Theron Brockman (DOB [REDACTED])  
Letter to Kathryn Keneally • January 14, 2020

Page 2

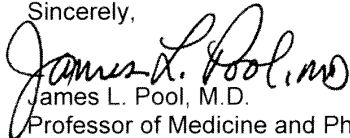
diagnosis. Dr. York and Dr. Yu concluded that Mr. Brockman's movements are consistent with Parkinson's Disease (or Vascular Parkinsonism). They also concluded his ongoing cognitive impairment is consistent with Lewy Body Dementia. These diagnoses cannot be totally confirmed except at autopsy of the brain after the death of the patient.

Parkinson's Disease (or Vascular Parkinsonism) and Lewy Body Dementia may each cause cognitive impairment and dementia. In Mr. Brockman's case, his recent neurological tests show mild to moderate dementia. In contrast to severe dementia, which will manifest as an inability of an individual to know where he is, what he is doing, or with whom he may be speaking, a person with mild to moderate dementia has some recognition of what is going on around him, and may function at a level at which he can cover-up his limitations. In a case such as Mr. Brockman, where an individual had superior, pre-morbid intelligence and functioned at a high level prior to the onset of dementia, he may be able to cover-up his limitations in social and business settings. In Mr. Brockman's case in particular, it became clear from my discussions with his wife and son that he has had a long-standing, excellent support network that enables him to appear to be continuing in his routine activities.

At this stage, Mr. Brockman has undeniable short-term memory limitations. Quite simply, if information is presented to him, he will be unable to comprehend what is being asked of him and to respond appropriately. In addition, his ability to report on past events may be distorted by the high risk of confabulation. When a person has dementia, his memory function will attempt to fill in gaps to enable him to respond to questions or to report on past events. While the story may sound logical, it will not be based on fact or accurate memory. The speaker will believe the story to be true, but is not. In essence, for a person such as Mr. Brockman, dementia will render long-term memory inaccessible and defective. Even if he can remember past events, he cannot accurately relate them to the question that he is being asked in the present or assimilate the information to report it accurately. If he can compose a response at all, it will likely be the product of such confabulation, rather than genuine memory.

For these reasons, I concur with the medical position that Mr. Brockman cannot assist his attorneys in his defense, if criminal charges were to be brought against him.

Sincerely,



James L. Pool, M.D.

Professor of Medicine and Pharmacology  
Baylor College of Medicine, Houston, TX



# **EXHIBIT M**



DEPARTMENT OF  
NEUROLOGY

**Joseph Jankovic, MD**

Professor of Neurology, Distinguished Chair in Movement Disorders  
Director, Parkinson's Disease Center and Movement Disorders Clinic  
Director, Center of Excellence for Parkinson's Foundation  
and Tourette Association of America

**Parkinson's Disease Center and Movement Disorders Clinic**

7200 Cambridge Street, 9th Floor, Suite 9A • Houston, Texas 77030  
713-798-2273 phone • 713-798-6808 fax • [www.jankovic.org](http://www.jankovic.org)



January 14, 2020

Kathryn Keneally  
Jones Day  
250 Vesey Street  
New York, NY 10281

Re: Robert Theron Brockman

Dear Ms. Keneally:

You have asked me to provide this letter for inclusion in a presentation that you plan to make to the U.S. Department of Justice on the issue of Robert Theron Brockman's cognitive impairment. You have let me know that you have reviewed the report that I prepared with regard to my examination of Mr. Brockman dated January 30, 2019, and that you will also be providing that report to the Department of Justice.

Specifically, I understand that you are asking whether Mr. Brockman can assist you in preparing a legal defense. It is my view that his cognitive impairment will prevent him from doing so.

My report discusses my diagnosis of Parkinson's disease or vascular parkinsonism. Based on my examination, and my understanding of subsequent examinations conducted by Dr. Melissa Yu and Dr. Michele York, I concur that Mr. Brockman has dementia.

Dr. Yu and Dr. York report that Mr. Brockman's symptoms support a diagnosis of Lewy body dementia. While I understand their reasoning, during my examination Mr. Brockman denied experiencing hallucinations, which are a hallmark indicator of Lewy body dementia. Notably there is no test that can be administered prior to autopsy that can confirm a diagnosis of either Parkinson's disease or Lewy body dementia.

It is characteristic that a person with dementia, such as Mr. Brockman, will be unable to recall information that is needed to respond accurately when asked questions. As a result of Mr. Brockman's cognitive impairment, he has trouble accessing information and making connections between questions that he is being asked and his recollection of events. It is a characteristic of this dementia that Mr. Brockman may engage in confabulation, in which the brain will attempt to fill in missing information, causing him to sometimes make up stories or provide information about something that has not occurred. Confabulation differs from prevarication or lying. Confabulation is a symptom of cognitive impairment, and is not voluntary. A cognitively impaired person who

engages in confabulation will believe that he is reporting truthfully. A person with Mr. Brockman's cognitive impairment may appear to be engaged in a normal discussion, but any information that he may provide may be partial and not complete or accurate.

In summary, Mr. Brockman's dementia leaves him unable to provide accurate information about past events.

Sincerely,

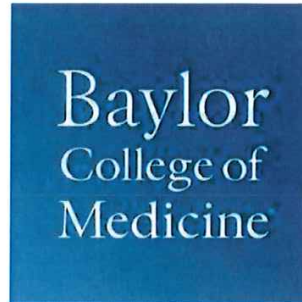
A handwritten signature in black ink, appearing to read "Joseph Jankovic". The signature is fluid and cursive, with the first name "Joseph" and last name "Jankovic" clearly distinguishable.

Joseph Jankovic, MD

# **EXHIBIT N**

Melissa Yu M.D.,FAAN

Alzheimer's Disease & Memory Disorders  
Center  
7200 Cambridge St, 9<sup>th</sup> Floor, Ste 9B  
Houston, TX 77030  
Phone: (713) 798-2273  
Fax: (713) 798-7434  
[www.bcm.edu](http://www.bcm.edu)



January 21, 2020

Kathryn Keneally  
Jones Day  
250 Vesey Street  
New York, NY 10281

Re: Robert T. Brockman

Dear Ms. Keneally:

At your request, I am providing this letter to respond to questions that you raised concerning my examination of Robert Brockman. I understand that you will provide a copy of my report dated February 20, 2019, and this letter to the U.S. Department of Justice.

You asked specifically about the comments made by Mr. Brockman's son that Mr. Brockman experiences fluctuations in decision-making ability. Patients with most forms of dementia experience anosognosia, which means that they lose insight into the cognitive limitations of their disease. Individuals with dementia may perceive themselves as functioning normally, even well. Individuals with dementia, who have good social instincts and expansive vocabulary may appear to function well on a surface level, and will retain "social niceties" despite sometimes-significant levels of cognitive impairment. Similarly, individuals who have been in business or professionally active for a long time may be able to speak on business issues in a way that appears functional, but will face difficulties when pressed for decisions or specifics. Patients with Lewy body dementia will often experience day-to-day and even hour-to-hour fluctuations in their ability to function.

Dementia of any kind is more than simple memory loss. The impact of dementia includes visual spatial function, language, memory, and executive function – in essence, all aspects of thought and cognitive function. As an example, if a requested action requires three steps, a person with dementia will have difficulty paying attention to the request, remembering each step, and resisting distraction while completing the action.

Sincerely,

A handwritten signature in black ink, appearing to be "Melissa Yu".

Melissa Yu, M.D., FAAN

# **EXHIBIT O**



**Michele K. York, PhD, ABPP-CN**  
Board Certified Clinical Neuropsychologist  
Associate Professor  
Department of Neurology

## CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Robert Brockman  
Date of Birth (Age): [REDACTED] (78 yr.)  
Date(s) of Evaluation: 12/03/2019  
Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor  
Referred by: James Pool, MD  
Referral Question: Independent Neuropsychological Examination

### BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male with a two to three-year history of short-term memory loss. The neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning was conducted by request by Kathy Keneally, Partner, Jones Day (New York). The following information was obtained during an interview with Mr. Brockman and his wife, his previous clinical neuropsychological evaluation conducted on 03/01/2019 and limited review of medical records.

Declarations: A forensic evaluation differs from a clinical evaluation in that there is no traditional doctor-patient relationship between the psychologist and the person being evaluated. The purpose of the evaluation is to assist Ms. Keneally in defense for Mr. Brockman's legal tax case; therefore, establishing a treatment relationship would create a potential conflict between the psychologist's role as an objective evaluator versus an advocate for the patient. Consequently, it is important that a retained expert avoid the role of treatment provider. This standard is mandated by the laws of the State of Texas (Texas Administrative code) as well as the Code of Ethics of the American Psychological Association (2010), and it represents the official position of the National Academy of Neuropsychology (Bush, 2005).

Dr. York was retained for a neuropsychological evaluation by Kathy Keneally of Jones Day. As explained above, she is excluded from providing any direct treatment to Mr. Brockman. Consequently, Dr. York's role was necessarily restricted to that of a forensic consultant rather than a treating doctor in this context. Mr. Brockman was informed of these conditions and consented to the evaluation and to his ability to understand these limitations.

Opinions reached in this report are based on direct interview and results of my neuropsychological evaluation and a review of his provided medical records to clarify the timeline of her medical procedures and hospitalizations. These opinions are based on current neuropsychological assessment techniques and research. Opinions are based upon reasonable neuropsychological probability and are subject to modification based on provision of additional information. The data from this evaluation is contained in Dr. York's confidential files.

**Previous Neuropsychological Assessment:** Mr. Brockman underwent a clinical neuropsychological evaluation with Dr. York on 03/01/2019. His general intellectual functioning (WAIS-IV FSIQ=87) fell within the low average range, which was a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuoconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found

CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION  
*Brockman, Robert*

**Michele K. York, PhD, ABPP-CN**  
Board Certified Clinical Neuropsychologist  
Associate Professor  
**Department of Neurology**

within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming. This pattern of neuropsychological performance indicated a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produced moderate familial distress. He demonstrated movements that were consistent with a parkinsonism disorder. These abnormal movements taken together with his current diagnosis of dementia, and REM Behavior Disorder, his pattern of cognitive impairments was reported as consistent with Dementia with Lewy Bodies (DLB).

**Current Concerns and General Condition:** Mr. Brockman and his spouse participated in the clinical interview. Mr. Brockman reported that his balance has declined over the past year. He has been using a balance board at the Houstonian but is not making any progress. He denied any falls.

On direct inquiry, he reported that his tax issues are about a small company that he sold to a family trust in 1981. He noted that the government is "mad at him" but "they don't say why," and they want to "confiscate the trust." He said the government is information gathering and talking to people he used to work with. He is concerned that the company will be "ruined" and this will affect the people who work there. He noted that he is starting to think about who will run the company. He reported that he thinks he can continue to be the chairman.

Mrs. Brockman described that her husband's cognition fluctuates on a daily basis from minute to minute. She described that he has "blank times" that he appears more confused. His wife noted that he was having difficulties at work and she had to help him type all of his employee performance reviews. She reported that he has increased initiation problems. He reported that he does not go into the office as much as he did in March 2019. He noted that it takes him longer to process information at work. His wife described that he sits at work for many, but he does not accomplish his tasks described. His short-term memory has continued to decline, and he is repeating himself more often. He is unable to recall details from his daily activities even later in the day. His procedural memory has also declined as he has forgotten how to tie a tie or to use a remote control for their television. She noted that he does not recall the code to unlock his telephone. He has difficulties completing tasks. His wife drives him to the office. She noted that he has declines in his spelling ability particularly while typing. He is unable to multi-task.

**Emotional Functioning:** Mr. Brockman reported that he began taking Wellbutrin which has improved his mood, but he continues to feel "slightly depressed." He noted that his diagnosis brings him "more down than before." He noted that he has realized that "all of sudden I am old." He denied heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he is harder to wake up. He is more violently acting out his dreams and has been kicking. He takes trazadone to aid his sleep. He has decreased appetite and has lost 20lbs over the past several months. His wife reported that he began to act out his dreams at least three years ago. He reported that he has floaters in his visual fields. He continued to deny visual hallucinations. It is noted that he had a previous visual illusion described below and a visual hallucination of a bug on the testing room floor that was not present to either the examiner or his wife during his evaluation in March 2019.



**CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION**  
*Brockman, Robert*

**Michele K. York, PhD, ABPP-CN**  
Board Certified Clinical Neuropsychologist  
Associate Professor  
**Department of Neurology**

**Previous Cognitive Complaints:** Mr. Brockman reported declines in his short-term memory over the past 2 to 3 years. He and his wife reported that he is repeating himself, losing possessions, losing his train of thought and is more tangential. He forgets names of new individual and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and has hit curbs while driving and parking. He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking.

**Medical History:** Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, hypercholesterolemia, glaucoma (mild), erectile dysfunction, tremor, micrographia, and back problems. He has plantar fasciitis, which reduces his exercise ability. He reported that he was hospitalized for a prostate infection and pericarditis four years ago. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa in February 2019. His wife noted a mild motor improvement when he first started on the medication, but when the medication was increased, he had increasing clumsiness. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines.

**Medications:** Wellbutrin 100mg tid, trazodone 50mg at night, Synthroid .75mg, Eliquis 2.5mg bid, aspirin, carbidopa/levodopa 25/100mg 2 tablets tid, stool softener, Exelon 2 patches. He noted that he also takes a regimen of vitamins and supplements.

**Social History:** Mr. Brockman has been married for 50 years, and they have one son. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

## **REVIEW OF LIMITED MEDICAL RECORDS**

**Dr. Joseph Jankovic Evaluation:** Mr. Brockman was evaluated by Dr. Joseph Jankovic on March 13, 2019 for his movement disorder. He was diagnosed with postural instability gait disorder subtype (PIGD) of parkinsonism. Dr. Jankovic noted that because Mr. Brockman denied hallucinations and cognitive fluctuations that he does not meet criteria for DLB; however, he acknowledged that he meets criteria for dementia. Mr. Brockman noted that he was worse physically and mentally despite taking levodopa, with a “zombie-like effect” as described by his wife.

**Dr. Melissa Yu Evaluation:** Mr. Brockman was evaluated by Dr. Melissa Yu on March 20, 2019 for his memory loss. Memory loss was dated to November 2017 in a medical chart note. Dr. Yu medical note stated that a DATSCAN was performed showing significant loss of dopaminergic signal, and he was started on Sinemet and the Exelon patch on 3/13/2019. Anosmia was reported for 10 years. Memory, word finding, and slowed processing speed were reported by his wife and son. His son noted that his father’s cognitive ability fluctuates, with episodes of “blankness” associated with less interaction alternating with improved cognition. His son also noted cognitive fluctuations in his father’s decision making abilities with good and bad days. It was noted that his son has him

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Associate Professor  
**Department of Neurology**

practice clock drawing to test his functioning. Dr. Yu's differential diagnoses included Dementia with Lewy Bodies or Parkinson's Disease Dementia. It was noted that the time course and fluctuations in cognition were more suggestive of DLB.

**BEHAVIORAL OBSERVATIONS:** Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his spouse who participated in the clinical interview. General appearance was neat and clean. The patient exhibited slowed motor behavior and gait and a mild tremor which was notable on drawings but did not interfere with his performances. He evidenced slowed response latencies. His mood was pleasant, but his affect was flat. Eye movements were normal. Vision (with corrective lenses) and hearing were adequate for the testing session. Conversational speech was coherent but was tangential in conversational speech. There was no evidence of paraphasias. His cognition tended to fluctuate throughout the testing session. He appeared to be confused at times even in the middle of tasks that he originally was completing accurately. He showed mildly decreased ability to follow directions, and he occasionally needed repetition of directions and lost place during set task. He exhibited cooperative test-taking behavior. His attitude towards the examiner was appropriate and friendly. He tended to minimize his cognitive impairments. He passed several embedded and stand-alone measures of performance validity; therefore, the following results are thought to be an accurate estimation of his current cognitive abilities.

#### **MEASURES ADMINISTERED**

Montréal Cognitive Assessment (MoCA); Caregiver Neuropsychiatric Inventory (NPI-Q); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVL-R); Neuropsychological Assessment Battery (NAB subtests: Daily Living Memory-Delayed, Daily Living Memory-Immediate, Daily Living Memory-Recognition, Naming, Numbers and Letters, and Visual Discrimination); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Verbal Fluency Test; Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Arithmetic, Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition); Wide Range Achievement Test (WRAT-4 subtest: Math Computation); Wisconsin Card Sorting Test (WCST); Instrumental Activities of Daily Living Scale (IADLS); Lawton and Brody Physical Self-Maintenance Scale (PSMS). Clinical Interview with patient and his spouse.

Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) measure as he was unable to comprehend task instructions and maintain task set independently. Informant questionnaires were completed by the patient's spouse.

#### **NEUROPSYCHOLOGICAL FINDINGS**

*The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).*

**Mental Status:** Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is moderately below expectation. He was fully oriented (6/6). He demonstrated difficulties with set shifting,

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visuospatial construction, sustained attention, repeating one sentence, serial subtractions, and with verbal fluency. He did not recall any words (0/5) and was not aided by category cueing. He was aided by multiple choice cueing for 4/5 words.

**Intellectual:** Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from low average to high average yielding a pro-rated Full Scale IQ estimate of 96, which is in the average range.

**Attention/Concentration:** Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was average with 6 digits forward, 4 digits backward, and 5 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was low average. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was deficient with 0 errors. Written math computation revealed a 5.6 grade equivalent. It is noted that he was unable to perform simple addition, multiplication and division arithmetic problems (e.g.,  $3 \times 4 = 7$ ,  $14/3$ ).

**Executive:** Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was borderline impaired. His abstract verbal reasoning was average. Working memory to perform mental arithmetic was average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued as he was unable to comprehend the task instructions and he was unable to set shift independently. Performance on a novel task of problem-solving and hypothesis testing fell in the low average range (11-16th percentile) with 1 correct category achieved by the end of the task. He made numerous "Other" responses that did not match to any of the 3 possible correct categories. He lost set one time and had to be reminded of the instructions after each card so that he would not match to the wrong set of cards. His performance fluctuated during this task.

**Memory:** Recall of culturally-based general knowledge was high average. Immediate recall of verbally presented contextual material was average ( $SS=8$ ). Delayed recall of the stories was low average ( $SS=7$ ). Retention of initially learned material was 50.0%. Recognition memory was average (16/23). Incremental learning for a semantically-categorized word list across 3 trials was deficient (1, 4, and 4 words per trial), and delayed recall was in the deficient range with 25.0% retention which falls within the deficient range. On recognition memory assessment, 10/12 target words were correctly identified, 3 false positive errors were committed, with discrimination accuracy in the borderline impaired range.

Immediate recall of basic geometric figures was borderline impaired ( $SS=4$ ). Delayed recall of the designs was deficient ( $SS=2$ ). Retention of the initially learned material was 0.0%. Recognition memory was average (2/7).

**Language:** Lexical fluency was borderline impaired with between 5 to 8 words per trial. Semantic fluency was low average with 14 exemplars generated. Confrontation naming of pictured objects was average (NAB Form 1; 29/31). He made an error of transitive limb praxis which was improved with imitation

**Visual-Perceptual:** His drawing of a complex geometric design scored in the low average range. He demonstrated a mild tremor but it did not interfere with his drawing ability. He maintained the overall gestalt but he distorted or omitted several of the internal details. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was within normal limits to command (CDT=10/10) and impaired

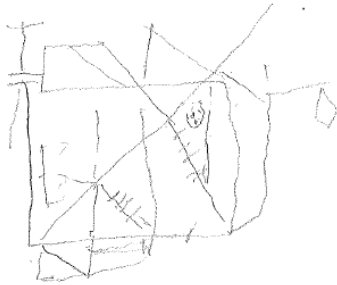
**CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION**  
**Brockman, Robert**

**Michele K. York, PhD, ABPP-CN**  
Board Certified Clinical Neuropsychologist  
Associate Professor  
Department of Neurology

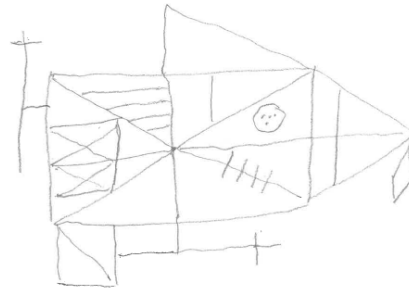
when copying a model (CDT=8/10). He drew the clock face and began placing the numbers accurately but then the numbers ended in the middle of the clock face. He placed the hands accurately to where he drew the numbers.

**Examples of visuospatial performances highlighting Mr. Brockman's fluctuating cognitive functioning.**

**Rey Complex Figure Test – Copy of a Design**



**03/01/2019**

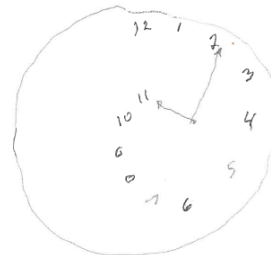


**12/03/2019**

**Clock Drawing**



**03/01/2019**



**12/03/2019**

**Mood / Personality:** On a self-report measure of anxiety, his responses fell in the minimal range (GAD-7=4/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of probable depression (GDS=19): presently unsatisfied with life, terminating activities and/or lack of interest, lack of hope regarding the future, ruminating thoughts, feeling as though something negative is going to occur, unhappiness, helplessness, preferring to stay home, worry about the future, declines in memory, downhearted and blue, lack of excitement for life, difficulty beginning new projects, poor energy, hopelessness, difficulties with concentration, difficulties with decision making, and general declines in thinking skills.

**Activities of Daily Living:** His spouse served as the informant completing a questionnaire regarding the patient's ability to complete basic and instrumental activities of daily living. Mr. Brockman reportedly has difficulties with self-care ADLs (PSMS=7/30). It was noted that he is constipated and goes to the restroom every half hour; he eats, dresses, grooms, and bathes very slowly. He requires assistance with ambulation. He requires assistance with instrumental activities of daily living (IADLs=14/31) including telephone use, shopping, food preparation,

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transportation, and finances. His wife noted that he seldom uses his phone. He fluctuates in his ability to handle money even with day-to-day expenses. She has to remind him to take his medications, and if she does not then she notices that he has forgotten to take doses.

**Neurobehavioral:** The patient's spouse completed an inventory assessing for the presence of neurobehavioral symptoms commonly associated with dementia, reportedly observing mild problems with disinhibition and motor disturbance and moderate problems with agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite (NPI-Q severity=12; distress=25) which produce an overall moderate to extreme level of familial distress.

### **SUMMARY AND IMPRESSION**

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male who underwent an independent neuropsychological evaluation as a component of a forensic evaluation. The factual matters stated in this report are, as far as I know, true, and the opinions in the report are genuinely held by me and the report contains reference to all matters I consider significant.

It is this examiner's opinion based on the testing conducted and behavioral observations that Mr. Brockman was putting forth full effort and was not exaggerating or embellishing the nature and extent of his cognitive impairment. It is noted that neuropsychological tests were chosen to best assess Mr. Brockman's cognitive abilities. The testing environment was optimal and the following results are considered a valid estimate of his current neuropsychological and emotional status.

Mr. Brockman currently operates in the average range of general intellectual functioning (WAIS-IV FSIQ=96), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30 (total), 6/6 (orientation), and 0/5 (short-term recall), which is moderately impaired. Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 14/30, and his wife indicated a significant decline in his functional ability.

Self-report of depression was elevated (GDS=19), but he did not endorse elevated levels of anxiety (GAD-7=4). The NPI-Q completed by his wife (severity=12; distress=25) indicated problems with disinhibition, motor disturbance, agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite for an overall moderate to extreme level of familial distress.

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of oral and written processing speed, executive functions (including working memory, problem solving, inhibition, set shifting, and verbal fluency), learning and recall of a word list, learning and recall of visual material, and basic visuospatial functioning. His intellectual functioning subtest scores remained within the broadly average range (low average to high average). It is noted that his verbal memory was aided by context with average learning of a story, but he only retained 50% of the material he originally learned after a brief delay (low average). His written arithmetic performance was a 5.6 grade equivalent with difficulties noted in performing basic addition, multiplication and division problems. His basic attention and language (naming and semantic fluency) performances were average.

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Comparison with prior results obtained on 03/01/2019 revealed the following pattern of interim changes:

**Declines were found in the areas of:**

- Verbal fluency (low average to borderline impaired)
- Graphomotor sequencing (borderline impaired to deficient)
- Learning of a word list (borderline impaired to deficient)
- Decreased functional abilities

**Improvements were found in the areas of:**

- Sequencing of digits (deficient to average)
- Learning and recall of contextual information (deficient to average and low average with only 50% retention)
- Clock drawing (impairments remain)
- Visuospatial construction of a complex figure

It is noted that Mr. Brockman's cognition fluctuated significantly throughout the evaluation. He demonstrated improvements on a few measures; however, during several tasks, he became more confused and demonstrated a blank stare expression. These fluctuations were more apparent during this evaluation as compared to his previous evaluation in March 2019. Mr. Brockman's pattern of neuropsychological performance indicates a dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. Mr. Brockman's current cognitive pattern and his parkinsonism, taken together with his dementia at the time of diagnosis of his movement disorder, cognitive fluctuations, and REM Behavior Disorder are consistent with a diagnosis of Dementia with Lewy Bodies (DLB). Visual hallucinations are a hallmark of DLB; however, up to 30% of patients with DLB do not demonstrate visual hallucinations particularly at the early stages of the disorder. Mr. Brockman reported a previous visual illusion and a mild visual hallucination was present during neuropsychological testing in March 2019, which further supports this diagnosis. His dementia falls under the diagnostic category of Lewy Body Dementias.

Based on the current cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it is my opinion that Mr. Brockman is unable to participate and aid in his own defense. He is unable to recall and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that will allow him to make comparisons and weigh his options.



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Michele K. York, PhD, ABPP-CN  
Board Certified Clinical Neuropsychologist  
TX License #31159

# EXHIBIT P

### Patient Information

**Name:** ROBERT THERON BROCKMAN  
**Medical Record Number:** 0300937767  
**Sex Code:** M  
**BirthDate:** [REDACTED]

### Exam Information

**Accession Number:** 201902140001  
**Modality:** NM  
**Body Part:** HEAD  
**Description:** NM DATSCAN BRAIN SPECT  
**Performed Date:** 2/14/2019 11:22:21  
**Patient History:** G20

### Final Report

Dopamine Transporter Imaging (DaTscan)  
Brain Imaging, tomographic (SPECT)

Reason for exam: G20: Parkinson's disease

Report: The patient received Lugol's solution 10 drops in 30 mL of water for thyroid blockade 30 minutes prior to injection of the radiopharmaceutical. I-123 ioflupane 4.5 mCi was administered intravenously. Tomographic images of the head were obtained at approximately 4 hours post administration of the radiopharmaceutical.

Tracer activity is visually absent in the bilateral putamina. Tracer accumulation is markedly decreased in the caudate nuclei relative to background tracer activity. Decrease of tracer is slightly greater in the right caudate nucleus compared to the left.

#### Impression:

Severe loss of dopaminergic neuronal function in the bilateral dorsal striata with loss greater on the right compared to the left.

Semi-quantitative analysis using the DaTQUANT program supports the above interpretation. The DaTQUANT report is included with the images on PACS.

Signed by: Dr. Julie Wendt, M.D. on 2/15/2019 7:22 AM

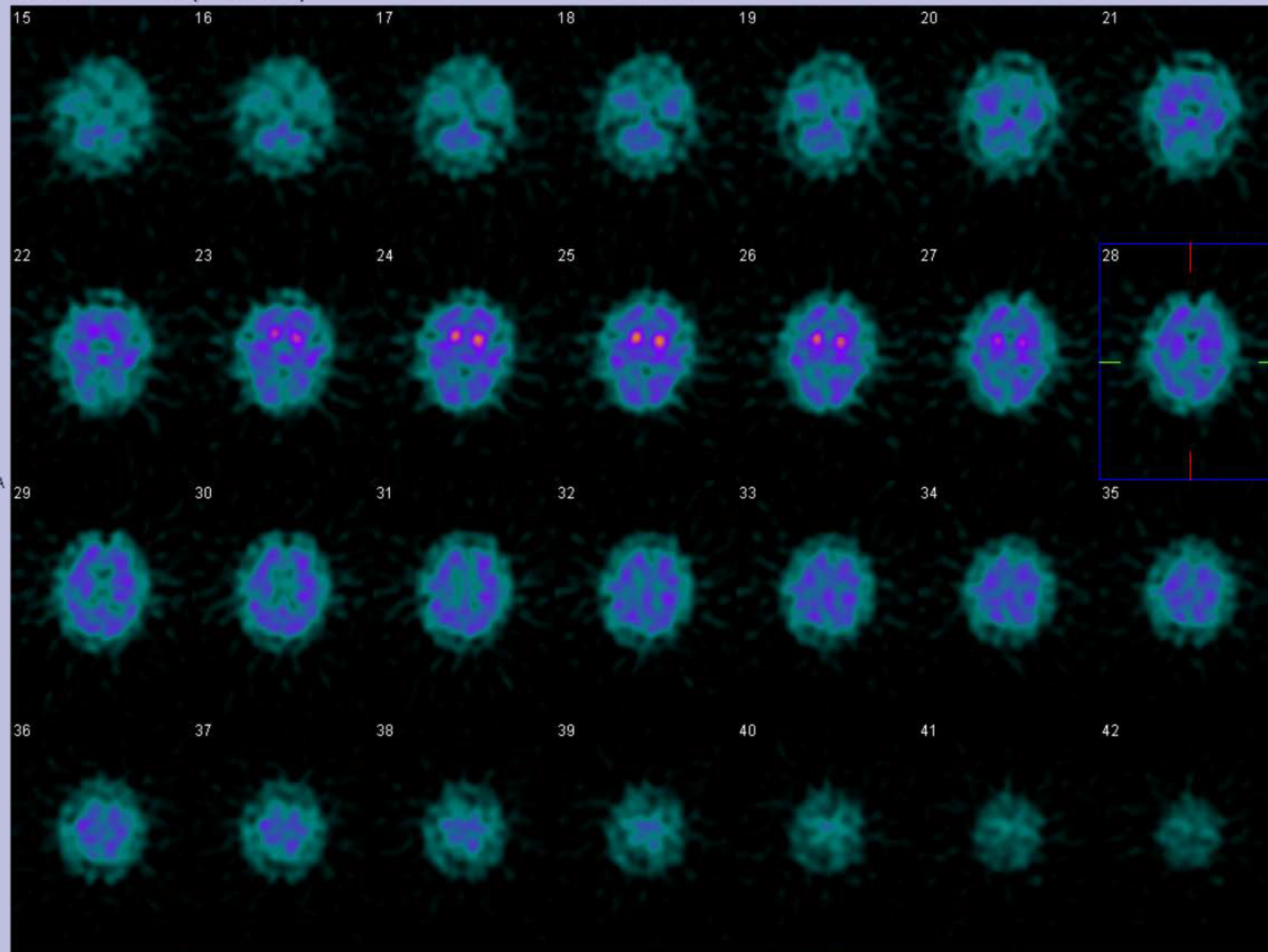
### Principal Interpreter

**Name:** Provider JWENDT  
**Provider ID:** JWENDT



Row A - DATSCAN BRAIN [Recon - NoAC]

Transverse



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95

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Posterior  
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Bottom  
to  
Top

A: (B:4%,T:95%)

Patient Name: BROCKMAN, ROBERT THERON

Patient ID: 0300937767

DOB: [REDACTED]

Case 3:20-cr-00371-WHA Document 64-2 Filed 12/08/20 Page 91 of 108

Study Name: BRAIN DATSCAN

Study Date: 2/14/2019

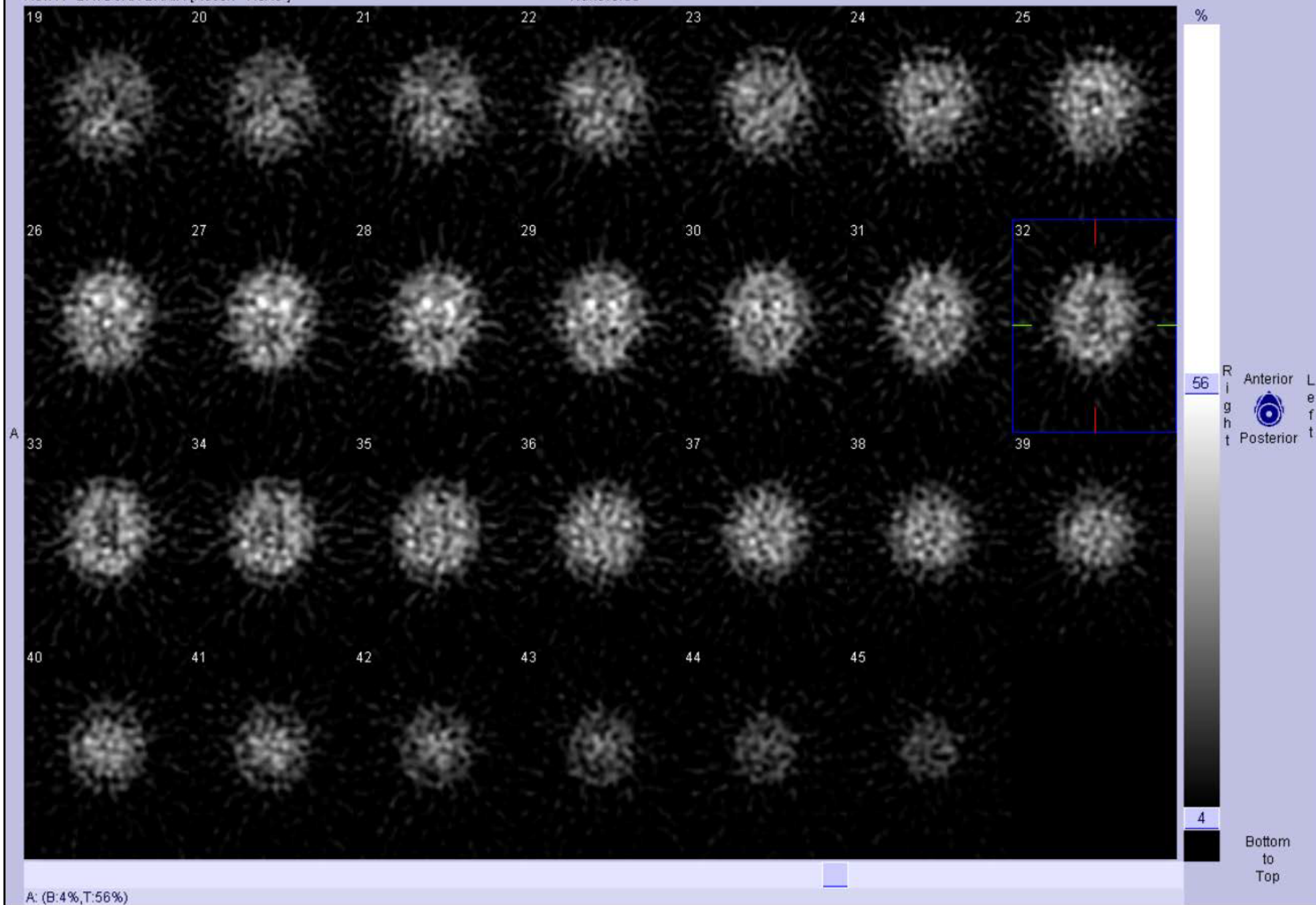
Baylor Clinic AV

Radiopharmaceutical 1: 0.0 MBq (0.00 mCi)

Study Time: 11:22:21 AM

Row A - DATSCAN BRAIN [Recon - NoAC]

Transverse





Patient Name: BROCKMAN, ROBERT THERON

Patient ID: 0300937767

DOB: [REDACTED]

Sex: M

Case 3:20-cv-00379-WHM Document 64-2 Filed 12/08/20 Page 92 of 108

Study Name: BRAIN DATSCAN

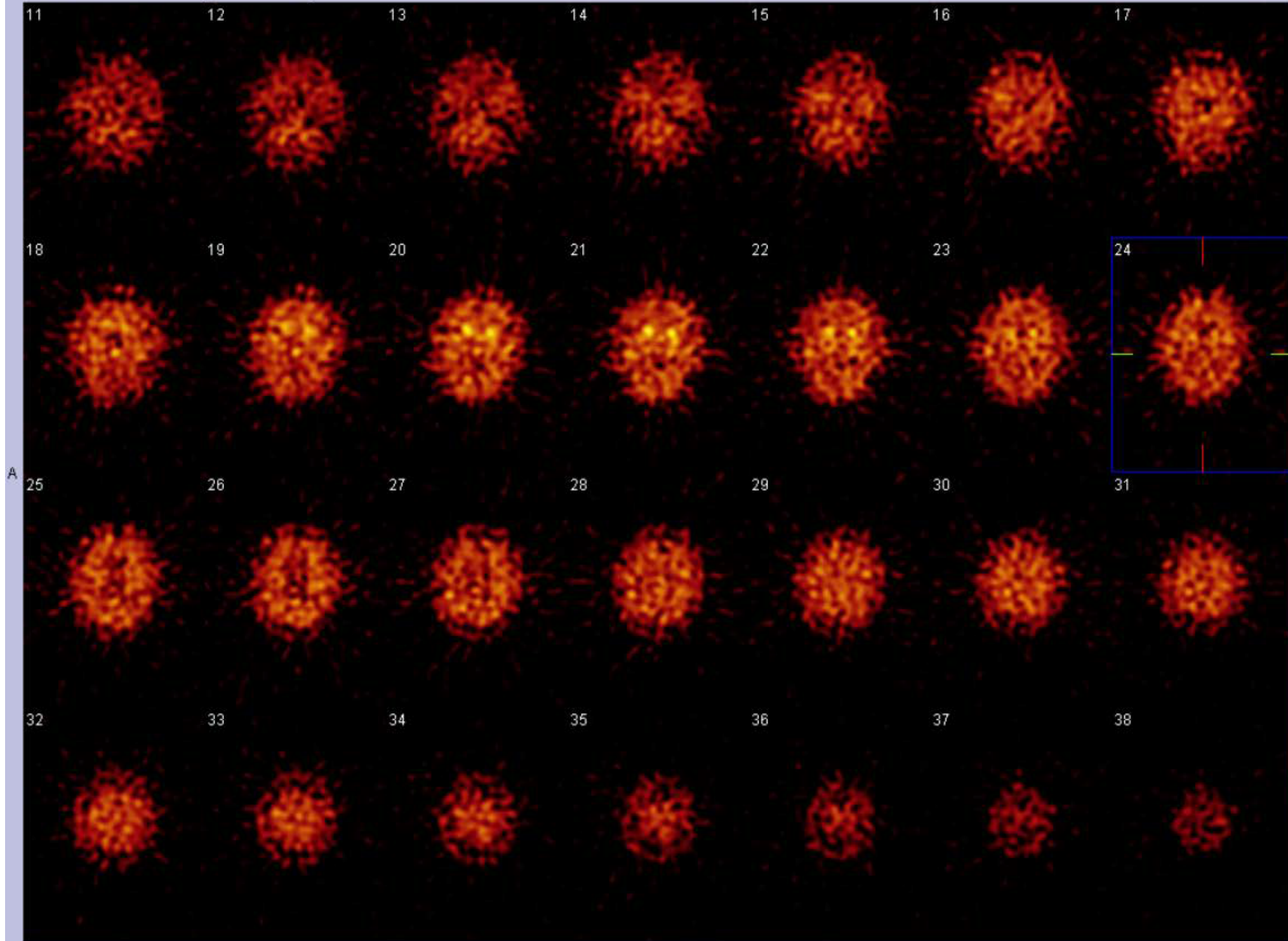
Study Date: 2/14/2019

Study Time: 11:22:21 AM

Baylor Clinic AV

Row A - DATSCAN BRAIN [Recon - NoAC]

Transverse



%

81

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Posterior  
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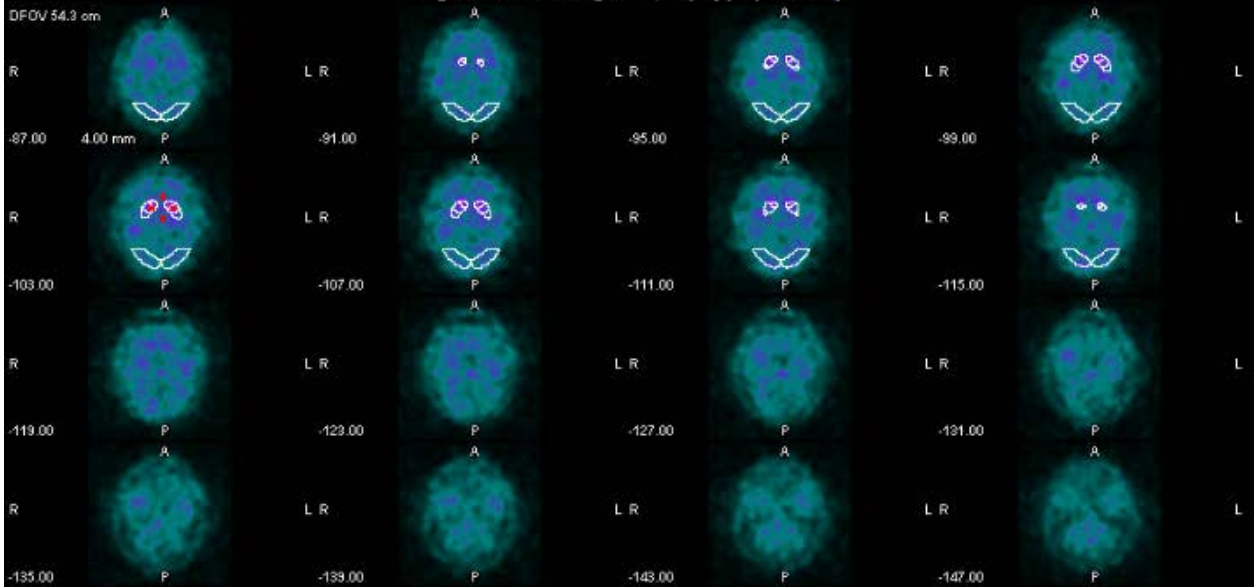
A: (B:6%,T:81%)

Patient Name : BROCKMAN ROBERT THERON  
 Exam Description : Tomo\_Transaxials  
 Referring Physician :  
 Data : IRNC REGISTERED  
 Camera : IP2  
 Collimator Type : Parallel  
 Dose (mCi) : 4.5  
 Radiopharmaceutical : DaTscan  
 Corrections : No Correction

Patient ID : 0300937767  
 Exam Date : Feb 14, 2019  
 Reading Physician : Julie Wendt  
 Age (Years) : 77  
 Collimator Name : LEHR  
 Counts (kCounts) : 2074.1  
 Gender : Male  
 Reconstruction Type : OSEM  
 Normal DB : GE OSEM NC NDB  
 GE normals database for OSEM with no correction

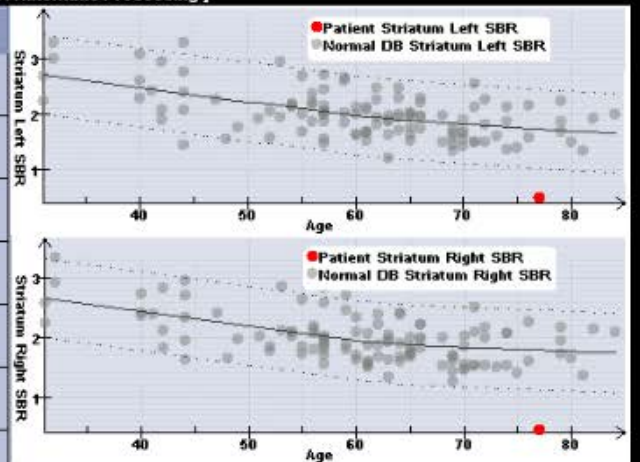
Manually Modified

Images are for non-diagnostic, display purposes only

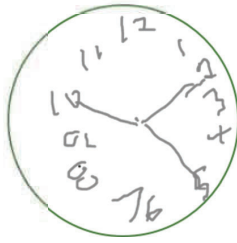


[ Non-Rigid Registration : Automatic Processing ]

	Measured	Mean ( $\pm 1$ SD)	Deviation	Z-Score
Striatum Right SBR	+0.46	+1.79 ( $\pm 0.23$ )	-74%	-3.98
Striatum Left SBR	+0.49	+1.73 ( $\pm 0.35$ )	-72%	-3.50
Putamen Right SBR	+0.36	+1.70 ( $\pm 0.33$ )	-79%	-4.09
Putamen Left SBR	+0.43	+1.63 ( $\pm 0.35$ )	-74%	-3.47
Caudatus Right SBR	+0.58	+2.01 ( $\pm 0.40$ )	-66%	-3.35
Caudatus Left SBR	+0.52	+1.94 ( $\pm 0.42$ )	-68%	-3.13
Striatum Asymmetry	+0.02	+0.03 ( $\pm 0.02$ )	-26%	-0.37
Putamen Asymmetry	+0.05	+0.03 ( $\pm 0.03$ )	+36%	+0.47
Caudatus Asymmetry	+0.03	+0.05 ( $\pm 0.04$ )	-24%	-0.30



# EXHIBIT Q

SCORE	TODAY	CLOCK DRAWING: TODAY
3-WORD MEMORY	2	
ORIENTATION	4	
SEQUENCE MEMORY	4	
TIME	3	
TOTAL SCORE	13	

### Background

This 79 year-old man with Parkinson's Disease and dementia has been tested today in clinic during his annual physical examination to monitor objective changes with these computerized metrics in his cognitive function. His wife (Dorothy) and son (Robert) report deteriorations in cognitive functions.

### Test Results:

Total score is 13 of 29 points. This score falls below the cutoff for dementia in patients of this age and educational level and is typically associated with Major Neurocognitive Disorder, moderate (formerly Moderate Dementia). In the CogniSense research database of 3,500 patients, no patients in this score range had normal cognition, 2% had Mild Cognitive Impairment (MCI), and 98% had dementia.

The test administrator agrees with the results of this test.

### Results Over Time



### Plan

1. Repeat comprehensive annual neuropsychological testing by Dr. Michele York is scheduled.

*James L. Poolino*

Patient ID: 03527911 DOB: [REDACTED] Age: 79 Gender: M



Disclaimer: This test has high levels of sensitivity, specificity and reliability, but does not replace comprehensive neuropsychological and medical evaluation. Our recommendations are based on current research and extensive clinical experience with this population. The CogniSense™ tool has been validated in English speaking adults ages 60 to 92 in a community-based primary care setting.

References:

- Clionsky, M and Clionsky E, "Development and Validation of the Memory Orientation Screening Test," American Journal of Alzheimer's Disease & Other Dementias, 2010, 25 (8), 650-656
- Clionsky, M and Clionsky E, "Identifying Cognitive Impairment in the Annual Wellness Visit: Who Can You Trust?", The Journal of Family Practice, 2011, 60: 653-659
- Clionsky, M and Clionsky E, "The Memory Orientation Screening Test (MOST®) accurately separates normal from MCI and demented elders in a prevalence-stratified sample," Alzheimer's Disease & Parkinsonism, 2013, 3:1

# **EXHIBIT R**





**Michele K. York, PhD, ABPP-CN**  
Board Certified Clinical Neuropsychologist  
Professor  
Department of Neurology

## CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Robert Brockman  
Date of Birth (Age): [REDACTED] (79 yr.)  
Date(s) of Evaluation: 10/07/2020  
Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor  
Referred by: James Pool, MD/Kathy Keneally, Jones Day  
Referral Question: Independent Neuropsychological Examination

### BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 79 year-old, right-hand dominant, Caucasian male with a three to four-year history of cognitive and behavioral decline. The neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning was conducted by request by Kathy Keneally, Partner, Jones Day (New York) and Dr. James Pool. The following information was obtained during an interview with Mr. Brockman and his son, Robert, his previous clinical neuropsychological evaluation conducted on 03/01/2019 and his previous forensic evaluation conducted on 2019 and limited review of medical records.

Declarations: A forensic evaluation differs from a clinical evaluation in that there is no traditional doctor-patient relationship between the psychologist and the person being evaluated. The purpose of the evaluation is to assist Ms. Keneally in defense for Mr. Brockman's legal tax case; therefore, establishing a treatment relationship would create a potential conflict between the psychologist's role as an objective evaluator versus an advocate for the patient. Consequently, it is important that a retained expert avoid the role of treatment provider. This standard is mandate by the laws of the State of Texas (Texas Administrative code) as well as the Code of Ethics of the American Psychological Association (2010), and it represents the official position of the National Academy of Neuropsychology (Bush, 2005).

Dr. York was retained for a neuropsychological evaluation by Kathy Keneally of Jones Day. As explained above, she is excluded from providing any direct treatment to Mr. Brockman. Consequently, Dr. York's role was necessarily restricted to that of a forensic consultant rather than a treating doctor in this context. Mr. Brockman was informed of these conditions and consented to the evaluation and to his ability to understand these limitations.

Opinions reached in this report are based on direct interview and results of my neuropsychological evaluation including an interview with Mr. Brockman and his son, Robert, and a review of his provided medical records to clarify the timeline of his medical procedures and hospitalizations. These opinions are based on current neuropsychological assessment techniques and research. Opinions are based upon reasonable neuropsychological probability and are subject to modification based on provision of additional information. The data from this evaluation is contained in Dr. York's confidential files.

**Previous Neuropsychological Assessments:** Mr. Brockman underwent a clinical neuropsychological evaluation with Dr. York on 03/01/2019. In 2019, his general intellectual functioning (WAIS-IV FSIQ=87) fell within the low average range, which was a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of

**CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION**  
**Brockman, Robert**

**Michele K. York, PhD, ABPP-CN**  
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Professor  
**Department of Neurology**

sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuoconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming. This pattern of neuropsychological performance indicated a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produced moderate familial distress. He demonstrated movements that were consistent with a parkinsonism disorder. These abnormal movements taken together with his current diagnosis of dementia, and REM Behavior Disorder, his pattern of cognitive impairments was reported as consistent with Dementia with Lewy Bodies (DLB).

Mr. Brockman underwent a second neuropsychological evaluation on 12/03/2019. This evaluation revealed average general intellectual functioning (WAIS-IV FSIQ=96), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30, which is a moderately impaired performance. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of oral and written processing speed, executive functions (including working memory, problem solving, inhibition, set shifting, and verbal fluency), learning and recall of a word list, learning and recall of visual material, and basic visuospatial functioning. His written arithmetic performance was a 5.6 grade equivalent with difficulties noted in performing basic addition, multiplication and division problems. His basic attention and language (naming and semantic fluency) performances were average. Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 14/30, and his wife indicated a significant decline in his functional ability.

Comparison with prior results obtained on 03/01/2019 revealed declines on measures of verbal fluency (low average to borderline impaired), graphomotor sequencing (borderline impaired to deficient), learning of a word list (borderline impaired to deficient), and decreased functional abilities. He demonstrated improvements in the areas of sequencing of digits (deficient to average), learning and recall of contextual information (deficient to average and low average with only 50% retention), and visuospatial construction of a complex figure, suggesting cognitive fluctuations. Confusion and a blank stare expression was noted during the evaluation.

Self-report of depression was elevated (GDS=19), but he did not endorse elevated levels of anxiety (GAD-7=4). The NPI-Q completed by his wife (severity=12; distress=25) indicated problems with disinhibition, motor disturbance, agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite for an overall moderate to extreme level of familial distress.

Mr. Brockman's pattern of neuropsychological performance indicated dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. His dementia taken together with his parkinsonism, cognitive fluctuations, and REM Behavior Disorder remained consistent with a diagnosis of a Lewy Body Dementia (Dementia with Lewy Body or Parkinson's Disease Dementia). Based on his cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it was opined that Mr. Brockman was unable to participate and aid in his own defense, and he was unable to recall

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and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that would allow him to make comparisons and weigh his options.

**Current Concerns and General Condition:** Mr. Brockman and his son, Robert, participated in the clinical interview. Mr. Brockman reported that his right hand tremor has progressed. He reported overall muscle weakness in his legs and an issue with his rotator cuff from tension and lifting weights. He noted that he discontinued taking his testosterone on his own. He is taking levodopa but he was unsure of his medication regimen as he noted his wife manages his medication box. He noted that he is continuing to use his balance board, but he tends to fall backwards and catch himself. He has not had any actual falls in which he has injured himself.

Mr. Brockman and his son described that his cognition has declined since December 2019 when he was last evaluated. He noted, in particular, his short-term memory and his working memory have declined and his processing speed is slower. He noted declines in his decision making abilities. He repeats himself and asks the same question again without insight. He forgot the passcode to unlock his phone, and he lost his phone. He forgets names of familiar individuals. He is disoriented to month and day of the week, which his family has noted when he is attempting to complete forms. He stopped driving 1 ½ years ago. He has increased word finding difficulties and attempts to google to find the word for which he is searching.

Emotional Functioning: Mr. Brockman reported that his mood is “not good.” He described that business has been difficult and his “morale is not what it used to be.” He is more apathetic. Due to COVID-19, his activities have been limited. He continues to work from home. He noted that the company did not have to lay anyone off and they have transitioned to working remotely. He is continuing to take Wellbutrin which has stabilized his mood. He denied heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he wakes up more often at 3am and is unable to get back to sleep due to anxiety. He relies on a sleeping aid (trazadone) a couple of times per week. He stated that he was yelling out in his sleep more often. He has decreased appetite with weight loss of 11lbs. He craves ice cream. He denied well-formed visual hallucinations, but he described that he will see things that look like bugs on a shirt, the floor, or a table and wait to see if it moves.

During a telephone call on 11/10/2020, Mr. Brockman’s son, Robbie, described a delusional incident that occurred on 10/17/2020 and 10/18/2020 with his father. Robbie reported that he went to visit his father on Saturday night for a couple of hours. He left the house around 7pm. His father woke up at 5am on Sunday and heard an external door opening and closing and his son’s car driving away. Mr. Brockman went to his office and reported that his computer was on and was unlocked. He stated that the computer was open to pages from the dark web and suicidal information. Mr. Brockman took pictures of the screens, which were actually Yahoo answer pages not related to the dark web or suicide. He was convinced that his son had returned to the house during the night and had broken into his computer. Once he was told otherwise, he thought someone else had entered the house and broken into his computer. The alarm had not been tampered with and there was no one on video entering or exiting the residence during the evening. The family had the computer hard drive analyzed by a third party and did not find any evidence of any tampering or that anyone had visited inappropriate websites. During this time, Mr. Brockman became overly concerned with when he would get his computer back asking numerous times per day.

**Previous Cognitive Complaints:** Mr. Brockman reported declines in his short-term memory over the past 3 to 4 years. Previously, he and his family reported that he repeats himself, loses possessions, loses his train of thought

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and is tangential. He forgets names of new individuals and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and hits curbs while driving and parking (He stopped driving 1 ½ year ago). He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking. Mrs. Brockman described that her husband's cognition fluctuates on a daily basis from minute to minute. She described that he has "blank times" that he appears more confused. His wife noted that he was having difficulties at work and she had to help him type all of his employee performance reviews. She reported that he has increased initiation problems. He noted that it takes him longer to process information at work. His wife described that he sits at work for many, but he does not accomplish his tasks. His short-term memory has continued to decline, and he is repeating himself more often. He is unable to recall details from his daily activities even later in the day. His procedural memory has also declined as he has forgotten how to tie a tie or to use a remote control for their television. She noted that he does not recall the code to unlock his telephone. He is unable to multi-task.

**Medical History:** Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, hypercholesterolemia, glaucoma (mild), erectile dysfunction, tremor, micrographia, back problems and increased balance problems. He has plantar fasciitis, which reduces his exercise ability. He reported that he was hospitalized for a prostate infection and pericarditis four years ago. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa in February 2019. His wife noted a mild motor improvement when he first started on the medication, but when the medication was increased, he had increasing clumsiness. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines.

Dr. Joseph Jankovic Evaluation: Mr. Brockman was evaluated by Dr. Joseph Jankovic on March 13, 2019 for his movement disorder. He was diagnosed with postural instability gait disorder subtype (PIGD) of parkinsonism. Dr. Jankovic noted that because Mr. Brockman denied hallucinations and cognitive fluctuations that he does not meet criteria for DLB; however, he acknowledged that he meets criteria for dementia. Mr. Brockman noted that he was worse physically and mentally despite taking levodopa, with a "zombie-like effect" as described by his wife.

Dr. Melissa Yu Evaluation: Mr. Brockman was evaluated by Dr. Melissa Yu on March 20, 2019 for his memory loss. Memory loss was dated to November 2017 in a medical chart note. Dr. Yu medical note stated that a DATSCAN was performed showing significant loss of dopaminergic signal, and he was started on Sinemet and the Exelon patch on 3/13/2019. Anosmia was reported for 10 years. Memory, word finding, and slowed processing speed were reported by his wife and son. His son noted that his father's cognitive ability fluctuates, with episodes of "blankness" associated with less interaction alternating with improved cognition. His son also noted cognitive fluctuations in his father's decision making abilities with good and bad days. It was noted that his son has him practice clock drawing to test his functioning. Dr. Yu's differential diagnoses included Dementia with Lewy Bodies or Parkinson's Disease Dementia. It was noted that the time course and fluctuations in cognition were more suggestive of Dementia with Lewy Bodies.

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**Medications:** Wellbutrin 100mg tid, trazodone 50mg at night, Synthroid .75mg, Eliquis 2.5mg bid, aspirin, carbidopa/levodopa 25/100mg 2 tablets tid, stool softener, Exelon 2 patches. He noted that he also takes a regimen of vitamins and supplements.

**Social History:** Mr. Brockman has been married for over 50 years, and they have one son, who is reported to have a diagnosis of an Autism Spectrum Disorder. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

**Behavioral Observations:** Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his son who participated in the clinical interview. General appearance was neat and clean. He exhibited slowed, unsteady gait and slowed motor behavior. He evidenced a mild tremor which was notable on drawings but did not interfere with his performances. His mood was pleasant, and affect was appropriate but somewhat flat. Eye movements were unremarkable. Vision (with corrective lenses) and hearing were adequate for the testing session. His cognition fluctuated throughout the testing session. He appeared to be confused at times even in the middle of tasks that he originally was completing accurately. Conversational speech was coherent, but at times he appeared confused, particularly with following directions, and he was tangential without insight. There was no evidence of paraphasias. He showed moderately decreased ability to follow directions, and he often needed repetition of directions due to confusion. He lost place frequently during set task. He exhibited cooperative test-taking behavior, and his attitude towards the examiner was appropriate and friendly. He lacked insight into the severity of his cognitive impairments. The following results are thought to be an accurate estimation of his current cognitive abilities. He passed embedded measures of performance validity; therefore, the following results are thought to be an accurate estimation of his current cognitive abilities.

## MEASURES ADMINISTERED

Montréal Cognitive Assessment (MoCA); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVLRT); Neuropsychological Assessment Battery (NAB subtest: Naming); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Verbal Fluency Test (SVF version: Animals); Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition). Clinical Interview with patient and his son. Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) measure due to cognitive/behavioral problems.

## NEUROPSYCHOLOGICAL FINDINGS

*The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).*

**Mental Status:** Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is below expectation. He was incompletely oriented (5/6, missing the date) and short-term recall was 0/5. He

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was aided by category cueing for one word and multiple choice cueing for 3 words. He demonstrated difficulties with set shifting, drawing a cube, and placing the hands on a clock face. These three tasks took him 15 minutes to complete, and he attempted the drawing of the cube twice unsuccessfully. He named 2/3 pictured animals. He also had difficulties with serial subtractions and verbal fluency.

**Intellectual:** Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from extremely low to average yielding a pro-rated Full Scale IQ estimate of 80 which is in the low average range.

**Attention / Concentration:** Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was borderline with 5 digits forward, 3 digits backward, and 3 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was extremely low. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was deficient with 1 error.

**Executive:** Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was deficient. His abstract verbal reasoning was average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued.

**Memory:** Recall of culturally-based general knowledge was average. Immediate recall of verbally presented contextual material was borderline impaired (SS=5). Delayed recall of the stories was borderline impaired (SS=4). Retention of initially learned material was 33.3%. Recognition memory was high average (20/23). Incremental learning for a semantically-categorized word list across 3 trials was deficient (3, 3, and 6 words per trial), and delayed recall was in the deficient range with 0.0% retention which falls within the deficient range. On recognition memory assessment, 9/12 target words were correctly identified, 5 false positive errors were committed, with discrimination accuracy in the deficient range.

Immediate recall of basic geometric figures was borderline impaired (SS=5). Delayed recall of the designs was deficient (SS=2). Retention of the initially learned material was 0.0%. Recognition memory was borderline impaired (1/7).

**Language:** Lexical fluency was low average with between 8 to 12 words generated per trial. Semantic fluency was deficient with 9 exemplars generated. Confrontation naming of pictured objects was high average (NAB Form 1; 30/31).

**Visual-Perceptual:** His drawing of a complex geometric design scored in the deficient range. Time required to copy design was borderline impaired. After 5 minutes of attempting to copy this design, the gestalt was not present, and he reported that he was unable to perform this task. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was impaired to command (CDT=6/10) and impaired when copying a model (CDT=7/10). On command clock on the MoCA, he drew the hands to the 10 and the 11 for "10 after 11," and he attempted to place the hands first prior to writing in the numbers. When later asked to draw a clock, he drew a clock face and the numbers 12, 3 and 5, with 13 tic marks and two hands pointing to the second and third tic mark for "10 after 11." When asked to copy a clock, he omitted the number 10 and wrote the numbers 12-7 in the right half of the clock. He did not maintain the hand size differentiation.



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**Motor Functioning:** Mr. Brockman is right-hand dominant. On formal examination, buccofacial, transitive, and intransitive classes of praxis were intact.

**Mood / Personality:** On a self-report measure of anxiety, his responses fell in the mild range (GAD-7=5/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of probable depression (GDS=20): presently unsatisfied with life, terminating activities and/or lack of interest, boredom, lack of hope regarding the future, generally poor spirit/mood, feeling as though something negative is going to occur, unhappiness, helplessness, preferring to stay home, worry about the future, declines in memory, downhearted and blue, worthlessness, lack of excitement for life, difficulty beginning new projects, poor energy, difficulties with concentration, lack of enjoyment first thing in the morning, and general declines in thinking skills.

### SUMMARY AND IMPRESSION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male who underwent an independent neuropsychological evaluation as a component of a forensic evaluation. The factual matters stated in this report are, as far as I know, true, and the opinions in the report are genuinely held by me and the report contains reference to all matters I consider significant.

It is this examiner's opinion based on the testing conducted and behavioral observations that Mr. Brockman was putting forth full effort and was not exaggerating or embellishing the nature and extent of his cognitive impairment. It is noted that neuropsychological tests were chosen to best assess Mr. Brockman's cognitive abilities. The testing environment was optimal and the following results are considered a valid estimate of his current neuropsychological and emotional status.

Mr. Brockman currently operates in the low average range of general intellectual functioning (WAIS-IV FSIQ=80), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30 (total), 5/6 (orientation), and 0/5 (short-term recall), which is moderately impaired. Self-report of depression was elevated (GDS=20), and anxiety was mildly elevated (GAD-7=5).

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of basic attention, oral and written processing speed, executive functions (including working memory, problem solving, inhibition, and set shifting), learning and recall of prose material and a word list, learning and recall of visual material, and basic and complex visuospatial functioning. His intellectual functioning subtest scores declined from his last evaluation ranging from the deficient to the average range. He continues to demonstrate average scores on fund of information, naming, verbal fluency, and verbal and visual reasoning.

Comparison with prior results obtained on 12/03/2019 revealed the following pattern of interim changes:

#### Declines were found in the areas of:

- Intellectual functioning (Full Scale Index: average to low average)
- Semantic fluency (low average to deficient)
- Inhibition (borderline impaired to deficient)
- Graphomotor sequencing (further in deficient range)

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- Basic attention (forward and backward: average to low average; sequencing: average to borderline impaired)
- Learning of prose material (average to borderline impaired)
- Delayed recall of prose material (low average to borderline impaired)
- Visuospatial construction (Clock drawing and Rey-O)

**No interim Improvements were found as compared to his performance on 12/03/2019.**

Mr. Brockman's current cognitive functioning was impaired across all domains assessed, with significant interim declines noted from his evaluation in March 2019. He continued to demonstrate significant cognitive fluctuations throughout the evaluation with confusion and impaired abilities to follow instructions. Mr. Brockman's pattern of neuropsychological performance continues to indicate a dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. Mr. Brockman denies experiencing well-formed visual hallucinations; however, he has experienced visual illusions, brief visual hallucinations, and a recent delusional episode. His current cognitive pattern and his parkinsonism, taken together with his dementia at the time of diagnosis of his movement disorder, cognitive fluctuations, and REM Behavior Disorder continue to suggest Dementia with Lewy Bodies. His cognitive profile demonstrated interim cognitive declines across all domains assessed.

Based on the current cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it remains my opinion that Mr. Brockman is unable to participate and aid in his own defense. Due to the neurodegenerative nature of this disease and the lack of effective treatments, his prognosis is for continued cognitive decline. He is unable to recall and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that will allow him to make comparisons and weigh his options.

It is this examiner's opinion based on record review, behavioral observations, patient interview, and current and previous neuropsychological assessments.



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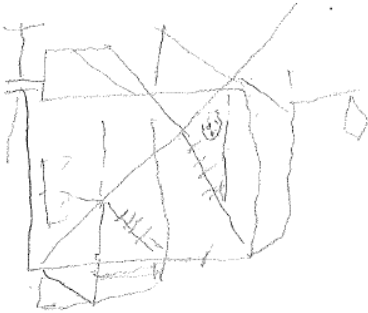
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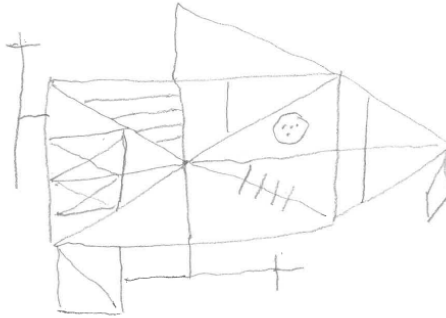
# **EXHIBIT S**

Examples of visuospatial performances for Mr. Brockman

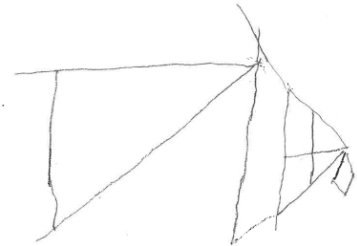
Rey Complex Figure Test – Copy of a Design



03/01/2019



12/03/2019

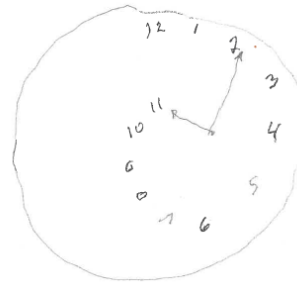


10/07/2020

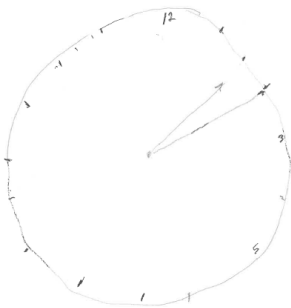
Clock Drawing "10 after 11"



03/01/2019



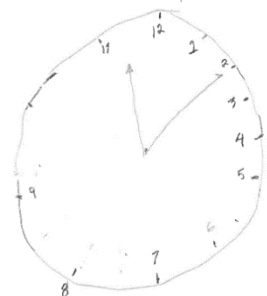
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10/07/2020

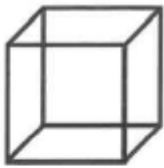


10/07/2020



10/07/2020

Copy



**Copy of a cube 10/07/2020**

**1<sup>st</sup> Attempt**



**Copy of a cube 10/07/2020**

**2<sup>nd</sup> Attempt**



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11 UNITED STATES DISTRICT COURT  
12 NORTHERN DISTRICT OF CALIFORNIA  
13 SAN FRANCISCO DIVISION  
14

15 UNITED STATES OF AMERICA,  
16 Plaintiff,  
17 v.  
18 ROBERT T. BROCKMAN,  
19 Defendant.  
20

Case No. 3:20-cr-00371-WHA

DECLARATION OF PETER J.  
ROMATOWSKI IN SUPPORT OF  
DEFENDANT ROBERT T.  
BROCKMAN'S MOTION FOR A  
HEARING TO DETERMINE  
WHETHER MR. BROCKMAN IS  
COMPETENT TO ASSIST IN HIS  
DEFENSE

21 **DECLARATION OF PETER J. ROMATOWSKI**  
22

23 I, Peter J. Romatowski, declare as follows:

24 1. I am a member of the bars of the District of Columbia, the states of Montana and  
25 New York, the United States Supreme Court and various other federal courts. I am of counsel to  
26 the law firm Jones Day, counsel for the defendant Robert T. Brockman. I make this Declaration  
27 in support of Defendant Robert T. Brockman's Motion For a Hearing to Determine Whether  
28 Mr. Brockman is Competent to Assist in His Defense.

GOVERNMENT  
EXHIBIT

4:21-CR-009-GCH  
No. 79

- 1 -

Decl. of Peter J. Romatowski in Support of Mot. For Hearing to Determine  
Whether Mr. Brockman is Competent to Assist in His Defense 3:20-cr-00371-WHA

1           2.     I served from 1979 to 1986 as an assistant United States attorney. In that role I  
2 investigated, prosecuted and tried cases involving the full range of federal offenses, with a  
3 particular focus on securities fraud. *See, e.g., United States v. Winans*,  
4 612 F. Supp. 827 (S.D.N.Y. 1985), *aff'd in part, rev'd in part sub nom. United States v.*  
5 *Carpenter*, 791 F.2d 1024 (2d Cir. 1986), *aff'd sub nom. Carpenter v. United States*,  
6 484 U.S. 19 (1987). Since 1986, I have been engaged in the private practice of law, specializing  
7 almost exclusively in white collar criminal defense, and defense of regulatory investigations and  
8 enforcement actions by the U.S. Securities and Exchange Commission. I am a fellow of the  
9 American College of Trial Lawyers.

10           3.     In the course of that experience, I have engaged with hundreds of witnesses, in  
11 order to gain their assistance in the prosecution or defense of federal criminal cases. This  
12 includes clients, one of whom was approximately Mr. Brockman's age, who assisted effectively  
13 in their own successful defense of complex regulatory charges in federal criminal jury trials. I  
14 have testified in a federal grand jury (as a law student) and in a federal criminal jury trial (while  
15 in private practice, called as a witness by the government). I believe that I recognize those  
16 cognitive and other skills that enable individuals to assist effectively in the prosecution or defense  
17 of such cases, whether as a witness or a defendant. It is my firm opinion that Mr. Brockman  
18 cannot do so.

19           4.     From that experience, I also have an appreciation of the participation that is  
20 necessary from knowledgeable witnesses in order to assemble and present in court a case of the  
21 complexity of this one, whether on behalf of the prosecution or the defense. Mr. Brockman's  
22 assistance is indispensable to the defense of the Indictment, and he is unable to render it.

23           5.     I first met Mr. Brockman when my firm was retained as his counsel in September  
24 2018. Between that date and March 2020 when the pandemic prevented further meetings in  
25 person, my colleagues and I met with Mr. Brockman ten times at his home in Houston, and once  
26 at a summer residence in Colorado. Each of these meetings was several hours in length. In  
27 addition, we have had countless meetings with Mr. Brockman by telephone.

28

1           6. By this declaration, I do not and do not intend to waive Mr. Brockman's attorney-  
2 client privilege or work product protection. I have not disclosed any conversation by which  
3 Mr. Brockman requested or we gave legal advice. I disclose below only that part of a  
4 conversation on July 18, 2019 which Mr. Brockman initiated for another purpose, to convey  
5 information to us concerning his medical condition, and my personal observations of his physical  
6 and cognitive condition.

7           7. On July 18, 2019, I met with Mr. Brockman at a summer residence in Aspen,  
8 Colorado. Two other Jones Day attorneys, Kathryn Keneally and Georgina Druce, participated in  
9 that meeting by conference call.

10          8. At the outset of the July 18, 2019 meeting, Mr. Brockman told us that he had an  
11 issue that he wanted to raise. He showed me a binder that contained medical reports. He  
12 explained that he had been diagnosed with Parkinson's disease and dementia. He expressed  
13 surprise concerning this diagnosis. He explained that he wanted us to understand that he may  
14 need us to address issues with him more slowly, that he may have some difficulty remembering  
15 what we told him, and that he may need to review things several times to understand what he  
16 needed to know. He never suggested or asked whether this medical condition would have any  
17 legal consequence for the criminal investigation.

18          9. We subsequently obtained the medical reports from Mr. Brockman. I now  
19 understand that Mr. Brockman's doctors diagnosed that he has cognitive impairment and other  
20 symptoms consistent with Parkinson's disease, parkinsonism, or Lewy body dementia, or some  
21 combination of the three.

22          10. The information provided in the medical reports is consistent with and helped me  
23 to better understand my experience with Mr. Brockman throughout this representation.

24          11. In my experience in communicating with Mr. Brockman, I have found that he has  
25 consistently been unable to assist in his defense, either by providing his own account of past  
26 events, or by providing leads to other evidence. He is unable to review and evaluate documents.  
27 I have also experienced repeated instances in which he did not retain information that we had  
28 provided to him. In certain instances, when we would provide him with information, he would



1 report it back to us a few days later, often in garbled form, as if it were something that he  
2 remembered separate from and without regard to having heard it from us. In other instances, he  
3 repeatedly provides us the same information, regardless of relevance.

4 12. I do not believe that this experience has been the product of any deliberate  
5 deception on Mr. Brockman's part. There have been many occasions where Mr. Brockman  
6 understood our questions sufficiently to recognize that an obvious answer – or any answer at all –  
7 would better serve his interests. Yet he is unable to provide any answer.

8 13. My experience with Mr. Brockman is consistent with – in fact is well explained by  
9 – the findings that I have read in the medical reports from his treating physicians.

10 14. Further, it has been my layman's observation that Mr. Brockman's disabilities  
11 have worsened over time. He has become more physically frail. He has slowed down in many  
12 respects, from his walking gait to his response time in ordinary conversation. He is having  
13 increasingly greater difficulty in understanding information that we provide or inquiries that we  
14 put to him.

15 15. Stated at its simplest, Mr. Brockman has proven unable to assist us in his defense.

16 I declare under penalty of perjury that the foregoing is true and correct.

17 Executed in McLean, Virginia, on December 8, 2020.

18  
19   
20 Peter J. Romatowski







**U.S. Department of Justice**

*United States Attorney  
Northern District of California*

(408) 535-5061  
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November 19, 2020

**VIA EMAIL**

Neal James Stephens  
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Jason Scott Varnado  
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*Re: United States v. Robert T. Brockman, 3:20-cr-00371-WHA (N.D. Cal.)*

Dear Counsel:

We understand you expect to file a motion in the above captioned matter asking the Court to evaluate Mr. Brockman's capacity under 18 U.S.C. § 4241. I am writing to request information that will help the government (and, ultimately, the Court) evaluate any representations the defense may make about Mr. Brockman's medical condition as part of that motion. Specifically, I would appreciate it if you would provide to the government all documents related to any medical and/or psychological treatment, diagnosis, or advice provided to Mr. Brockman by any physician or other medical professional in the last ten years, whether those records are maintained by Mr. Brockman or the provider. This request includes test results, labs, imaging, and notes, and is not limited to medical records associated with the reports you have already provided. At the very least we would expect this request to include records from the following practitioners:

- James Poole, MD,
- Michele York, PhD,
- Seth Paul Lerner, MD,
- Joseph Jankovic, MD,
- Melissa Michelle Yu, MD,
- Stuart Yudofsky, MD, and
- Mr. Brockman's general practitioners, as well as any practitioner who has diagnosed, treated, or consulted on the issues Mr. and Mrs. Brockman described to Pretrial Services (Parkinson's, atrial fibrillation, thyroid condition, cancer, and depression).

We would also request that Mr. Brockman provide HIPPA waivers to replace the waivers you withdrew in October, in order to permit his providers to discuss Mr. Brockman with government personnel, including experts.

**GOVERNMENT  
EXHIBIT**

**4:21-CR-009-GCH**

**No. 80**

Early disclosure of this material may allow us to narrow any issues in dispute, and to bring any unresolvable disputes to the Court's attention more quickly.

Please note that we expect to ask the Court to order that the government and any retained or appointed experts be given access to the materials requested above prior to any competency determination, so you may be wise to begin collecting them now regardless of whether you intend to provide them voluntarily.

Naturally, we recognize that information provided in response to this request may be covered by HIPPA, or otherwise sensitive, and would handle it accordingly.

Please feel free to let me know if you have any questions or concerns, or if you would like to discuss further.

Very truly yours,

DAVID L. ANDERSON  
United States Attorney

s/ Michael G. Pitman  
MICHAEL G. PITMAN  
Assistant United States Attorney